Smoking and Vaping Health Needs Assessment

June 2024

Suffolk Knowledge Intelligence And Evidence Team

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This report was written and finalised during spring 2024. During this period elections for the Prime minister were announced, and the future of the proposed Tobacco and Vaping (smokefree generation) bill was uncertain. This document retains references to the proposed Bill for now- and can still be used as a key local resource. It will be reviewed late summer/ early autumn 2024. At which point we hope there will be further clarity around the tobacco and vaping bill. We will then update the Health Needs Assessment accordingly.

Executive Summary

Smoking

Smoking remains a major public health issue in Suffolk, contributing to nearly 1,000 deaths per year and costing an estimated £747 million annually. Tobacco presents the single greatest risk for early deaths in Suffolk. This means that using smoked tobacco products poses a greater risk than other issues such as high blood pressure, obesity, alcohol, and air pollution. While Suffolk's smoking adult prevalence of 14% (around 84,900 people) is a similar percentage to the England average, accelerated progress is needed to reach the national "smokefree" ambition of 5% or less prevalence (equating to 38,169 smokers in Suffolk) by 2030.

Smoking disproportionately affects certain populations both nationally and in Suffolk. High smoking rates persist among, those in the armed forces and veterans, people with substance abuse disorders, people experiencing homelessness, LGBTQ+ individuals and prisoner populations. Smoking prevalence is also higher in people living in deprived areas, among some ethnic minority groups like Gypsy, Roma, and Traveller communities and among people living in social housing. In Suffolk, high smoker prevalences were evident in those with mental health conditions and routine and manual workers. Maternal smoking rates in Suffolk have declined but remain above the national target.

Population Health Management (PHM) data also showed that some patients living in Suffolk, registered to a GP in Suffolk and North East Essex Integrated Care Board (SNEE ICB – this excludes Waveney) with a history of smoking (in the past year) also had a recorded long-term conditions such as Chronic Obstructive Pulmonary Disease (COPD) (10.1%), high blood pressure (hypertension) (24.7%), and mental health conditions (45.7%). Smoking persists across the county, contributing further to chronic disease. On average, smokers incurred higher healthcare expenditures, mainly due to unplanned hospital admissions.

The Healthwatch Suffolk report: Smoking, vaping, and using tobacco in Suffolk: A summary of lived experience was commissioned for this Health Needs Assessment. It analysed 82 survey responses and 8 in-depth case-study interviews with individuals of varying age, gender, ethnicity and life experiences. The report highlighted several key themes around smoking behaviours in Suffolk. Many respondents started smoking at a young age, influenced by social norms and peer pressure. Smoking was commonly used as a coping mechanism for stress, mental health challenges, and life events - reinforcing addictive cycles. While health concerns motivated some to want to quit, others felt desensitised to the risks of smoking messaging or lacked sincere desire to stop smoking. The engagement emphasised the importance of understanding each smoker's personal story, level of self-reflection and readiness to stop smoking when using stop smoking services.

Suffolk currently provides a range of stop smoking services aimed at helping residents quit tobacco use. The four main branches of stop smoking services include the Feel Good Suffolk Stop Smoking Programme, projects supporting specific population groups (such as the routine and manual stop smoking project), the Tobacco Dependency Treatment Programme (delivered within NHS secondary care) and the Primary Care Stop Smoking Provision. These branches include offering free access to pharmacotherapies like nicotine replacement therapy (NRT) and vapes or e-cigarettes combined with Very Brief Advice (VBA), online information and behavioural support delivered by trained practitioners. Services are provided through face-to-face consultations, telephone/video sessions, and a group seminar (Allan Carr Easyway to Stop Smoking).

Quitting smoking has health benefits for both physical and mental wellbeing. In 2022/23, Suffolk's stop smoking services aided over 1,800 quitters per 100,000 residents in staying smoke-free for at least 4 weeks. However, referrals from healthcare settings have decreased in recent years. Suffolk has been allocated over £1 million in new annual funding to deliver an additional 14,000 quit dates over the next 5 years through increased promotion, treatment capacity, and referral pathways.

Local strategies and initiatives highlight the importance of addressing smoking as a priority area for Suffolk. The Core20PLUS5 framework identifies accelerating improvements in smoking cessation as one of its cross-cutting themes for reducing healthcare inequalities. Suffolk's 2022 Annual Public Health Report identified smoking as a potential focus for certain Integrated Neighbourhood Teams due to high smoking rates. The

county's Joint Local Health and Wellbeing Strategy for 2022-2027 emphasises the need to reduce unhealthy behaviours like smoking, noting associations between smoking and socioeconomic factors like type of employment. The SNEE Joint Forward Plan 2023-2028 sets supporting smoke-free living, and systematically screening hospital inpatients for smoking status as key priorities under its goal of reducing tobacco dangers across the population.

Vaping

"If you smoke, vaping is much safter; if you don't smoke, don't vape; marketing vapes to children is unacceptable."
Professor Sir Chris Whitty, 2023

The rise of vaping has introduced a new landscape of uncertainty and evolving perspectives around nicotine consumption. These new products have rapidly gained popularity, leaving questions about their long-term health impacts. The long-term health impacts of vaping remain uncertain given the relatively recent emergence of these products. However, current evidence indicates vaping poses substantially lower risks than smoking combustible cigarettes in terms of toxicant exposure and biomarkers for major diseases. Most health authorities consider vaping harmful for never-smokers, especially youth, but potentially beneficial for adult smokers who completely switch from cigarettes. However, it is important to note that nicotine exposure from vaping can still lead to dependence and adverse effects.

In Suffolk, vaping has been steadily rising with 1.7% of the population recorded as current or former vapers as of early 2024. Mirroring national trends, men engage in slightly less vaping than women locally. The prevalence peaks among the 50-59 year old age group.

A concerning increase in vaping prevalence among young people has also been shown in recent years, with 9% of 11-15 year olds in England currently vaping as of 2021. In Suffolk, 11.6% of children reported trying a vape in 2023, a significant rise from 7.7% in 2022. Elevated rates were also shown among those reporting disabilities, females, ethnic minorities including Gypsy, Roma, and Travellers, and those in their older teenage years. Most youth vaping is experimental, often influenced by peer pressure, curiosity, and appealing flavours. The growth of cheap accessible disposable vape products heavily marketed through retail and online channels is thought to enhance this growing prevalence. While vaping is less harmful than smoking for adults utilising them as a smoking cessation tool, this rising popularity among youth who have never smoked is a public health concern.

The Healthwatch Suffolk report: Smoking, vaping, and using tobacco in Suffolk: A summary of lived experience stakeholder engagement found that vaping and e-cigarettes had a mixed perception among participants. While some embraced vaping as an effective nicotine replacement product used to quit smoking cigarettes, others were anxious about vaping due to concerns around regulation, safety, and behavioural control. Notably, 43% of survey respondents had used vapes to quit smoking cigarettes. Vaping was seen as an effective nicotine replacement compared to other NRTs (such as patches/gum), as it capitalises on the behavioural reinforcement loop associated with the hand-to-mouth behaviour of smoking. However, the results highlighted challenges in making the switch to vaping, indicating the need for better guidance and support for smokers to effectively use vaping as a quitting aid and eventually transition out of vaping once they have successfully stopped smoking.

To address risks, new proposed legislation aims to reduce youth vaping by restricting sales of disposable vapes, curtailing child-appealing flavours and packaging, and enhancing retail display regulations, while still preserving vaping's harm reduction potential for adult smokers. Local enforcement efforts have escalated, with Trading Standards seizing increasing volumes of illicit vape products and investigations of sales to underage buyers.

Recommendations for Suffolk

High Level Recommendation	Specific recommendations

Target Populations
 	
1. Prioritise and intensify efforts to support smoking cessation among high smoking prevalence groups including those who are at higher risk from the negative health and economic impacts of smoking, and those who may need higher levels of support to stop smoking.
 	
Why?
The data and evidence presented in this HNA indicates there are specific geographical areas and population groups that experience higher smoking prevalence and worse health outcomes.
	1.1) **Target geographical areas of high prevalence of smoking**
	
	• Babergh, Mildenhall & Brandon, Newmarket, Haverhill, Lowestoft, Felixstowe, and Ipswich (both IP1 & IP2, and IP3 & IP4).
	
	1.2) **Routine and Manual workers**
	
	• Extend Suffolk's routine and manual worker project to all of Suffolk.
	• Insight work to understand why Babergh has the highest smoking prevalence in this group (24.8%) and are 3.7 times more likely to smoke than other occupations.
	• Offer options of intensity of support e.g. light touch with minimal support up to Russell Standard of support.
	• Continue to use the COM-B behaviour change model to initiate setting of quit dates and engagement.
	• Build relationships with smokers to ensure quit data is collected.
	• Address the barrier to quitting e.g. smoking with a drink and fear of weight gain.
	• Include a specific target group of young women. Nationally, 40% of mothers in routine and manual occupations were most likely to have smoked before or during pregnancy, in 2023/23 20.8% of women aged 20 and under were current smokers at time of booking their maternity appointment.
	• PH&C complete a profile of routine and manual workers and health in recognition that smoking does not sit in isolation.
	
	1.3) **High socio-economic deprivation**
	
	• Refer to the Suffolk Poverty Strategy and work in partnership with the strategy partners to further understand and develop interventions to stop smoking for
	  ○ Smokers in Lowestoft and Ipswich which have the most Local Super Output Areas (LSOAs) with a high Index of Multiple Deprivation (IMD) score.
	  ○ 2,900 estimated to be out of work and smoking (long term smokers are 7.5% less likely to be employed).

- 15,000 households with a smoker who fall below the poverty line.
- 27.2% of those with no qualification who smoke.

1.4) **Social housing providers and residents.** *People living in social housing are 3 times more likely to smoke than those in private tenure.*

- Use the Suffolk Housing Health Needs Assessment to inform interventions recognising that smoking does not sit in isolation.
- Develop targeted initiatives to reduce smoking in tenants and staff.
- Additional focus on those who are caregivers to children who reside in social housing.

1.5) **People experiencing homelessness and those who support services them.** *75% of people experiencing homelessness wanted to stop smoking (2019)*

- Work with homelessness agencies to make smoking a higher priority in their assessments of the heath needs of the people they support.
- Consider e-cigarettes and the light touch intervention swap to stop option because they offer a less structured and less formal approach to continue using nicotine.
- Work with West Suffolk who have the highest number of homeless households and owed a relief duty (n570).

1.6) **People with severe mental illness (SMI) to stop smoking.** *59% people with a SMI smoke.*

- Support a SMI Community TDTP discharge pathway to maintain smoking cessation.
- Support people with an SMI living in the community to stop smoking.
- Focus on Ipswich and East Suffolk which has the highest smoking prevalence of people with a long-term mental health illness.
- Explore how to support people to stop smoking with a diagnosis of lower level but ongoing mental health issues such as anxiety, depression, low mood and sleep disturbance (prevalence ranging from 40% - 47%) including working with Talking Therapies (Suffolk Wellbeing Service).
- Campaigns to educate on smoking's detrimental effects on mental health and myth bust on it relieving stress.

1.7) **Substance misuse.** *51% of people who have a substance misuse record with the GP smoke (SNEE). Nationally only 4% of people were recorded as being offered referral for smoking cessation interventions.*

- Improve pathways and opportunities for to assist smokers to quit**.**
- Carry out further research into what stop smoking interventions work for people with substance misuse.

1.8) **Minority ethnic groups. Suffolk has an overall minority ethnic population of 12.7% (2021)**

- Work with Gypsy Roma Traveller communities to develop appropriate stop smoking interventions (national data smoking prevalence 24%). Use the GRT Health Needs Assessment to understand wider health and determinants.
- Engage with smokers from Polish, Bulgarian, Romanian and Portuguese communities. Provide information in non-English languages.
- National data (2022) has 17% of people from mixed ethnic backgrounds as smokers. Research needed in Suffolk to better understand who this is, why this is and how an approach is taken to reduce this prevalence.
- Expand research and engagement with minority ethic groups in Suffolk to collect data understand smoking prevalence in populations and ways to support quitting smoking.

1.9) **Armed Forces** *(24% smoking prevalence)* **and Veterans** *(up to 1 in 10 with a smoking related disease).*

- Take learning from the Tri-Service Tobacco Control Working Group.
- Focus on veterans have short service or fail to complete the minimum engagement as they have poorer health outcomes.
- Focus on the Army who have higher smoking rates.

1.10) **LGBTQ+ communities** *Smoking prevalence recorded by people gay or lesbian 22.2% (national data 2018)*

- Work with Suffolk LGBTQ+ communities to understand smoking prevalence and stop smoking approach and interventions.

1.11) **Cohabiting/single people.** *People that reported 'cohabiting' or 'single' in relation to relationship status had higher smoking prevalence compared to 'married or civil partnership' and 'widowed, divorced or separated'.*

- Target smoking cessation initiatives at the 'cohabiting' or 'single' community

1.12) **People involved with the criminal justice system and within Suffolk prisons**. *Higher rates of smoking resumption on moving from closed to open conditions was reported*.

- Work with Hollesley Bay Category D prison to understand smoking rates, stop smoking provision and support to stop/maintain stop smoking upon release.
- Work with probation services to understand and enhance stop smoking support for their clients

1.13) People experiencing violence in their homes. *Whilst the number is small, local estimates from 2024 indicate that around 2/3rds of people in domestic abuse refuges in Suffolk smoke.*

- Work with refuges to understand how to support people who wish to stop smoking.

1.14) People with long term conditions. *24.4% in Suffolk with a history of smoking within the past year have hypertension. In SNEE ICB around 1 in 10 people with a history of smoking in the past year have chronic respiratory disease.*

- Collaborations with services and support to understand the barriers to stopping smoking for people with Hypertension and COPD and develop support to assist them to stop smoking.

2. To support pregnant women and the people around them to stop smoking. **Why?** Smoking results in worse health outcomes for both mother and baby and build on existing targeted to minimise the number of women smoking whilst pregnant, and to help them remain smoke free post pregnancy. This aligns with the case for change in the Smokefree Generation legislation. Suffolk's proportion of mothers known to be smokers at the time of delivery was 7.7% (2022/23). In the last 3 years (from 2020/21) percentages have remained relatively static, indicating that there needs to be a renewed focus on smoking cessation in this group. In 2021, the average age of mothers who gave birth in England and Wales was 30.9 years. Over 1 in 4 female smokers are of childbearing age (20-39 years). In 2023/23 20.8% of women aged 20 and under were current smokers at time of booking their maternity appointment.	2.1) Targeted work to support pregnant people to stop smoking in the high-risk population groups identified in Recommendation 1, especially those who are planning a pregnancy, young women or are younger mothers. *In April 2023, the Government announced that all pregnant women who smoke will be offered financial incentives in the form of vouchers alongside behavioural support by the end of 2024.* 2.2) Work with the TDTP to support the new financial incentive scheme for pregnant people and their partners to quit. Ensure smooth pathways in to onwards support, supports this scheme. 2.3) Focus on preventing people from relapsing post pregnancy. ○ Develop and support specialist stop smoking service for people who are discharged from the maternity TPTP stop smoking pathway and people around a pregnant person to stop smoking. ○ Consider campaigns to support stopping relapse e.g. other ways to have time away from the children other than smoking.
3. Prevent children and young people from taking up smoking and vaping and support them to stop **Why?** Smoking is bad for health at any age, and children should not be smoking or vaping. Many adults start smoking in adolescence, and there is an opportunity to prevent smoking in future generations. This aligns with the case for change in the Smokefree Generation	3.1) At the time of writing this HNA, PH&C are conducting a survey to better understand youth vaping/ smoking across Suffolk. The findings of this survey should be used alongside published research, guidance, and other examples of good practice to influence local plans to prevent young people starting to vape. 3.2) Form and sustain a multi-agency approach to reducing smoking and vaping in young people and preventing uptake. 3.3) Draw from national resources and work regionally with colleagues in the system to create a unified and best practice approach to campaigns, education, and support.

legislation, should it be implemented post general election (July 2024) The Healthwatch report and behavioural systems map demonstrated how immediate consequences are more relevant than distant ones (despite the 'cost' of each) for young people. As such, any prevention strategies with children and young people should aim to tackle these challenges.	3.4) Involve children and young people and agencies close to them to continue research into smoking and vaping in Suffolk. 3.5) Target work to prevent uptake and reduce smoking and vaping (in never smokers) in the priority groups in recommendation 1. 3.6) Because socially beneficial factors are implicit in starting smoking in CYP, and outweigh factors relating to future health, prevention activities with children and young people should focus on social factors (as well as health). 3.7) Explore how prevention work with young people could utilise immediate consequences (e.g., incentivisation with immediate rewards).
4. Enhance delivery models for stop smoking services and look for opportunities to utilise the additional local funding to facilitate 14,027 additional quit dates over 5-years. **Why?** Public Health and Communities has been allocated £1m/year for 24/25 (with further funding for up to 5 years to be confirmed by the incoming government) for additional stop smoking services. Decisions on how the funding is spent should be informed by the information provided in this Smoking and Vaping HNA. The Healthwatch and behavioural systems map demonstrated that smokers vary on many psychological factors. Yet, self-awareness, and various other self-theories (e.g., ideal self) can help to shape support work. Delivery models can be greatly enhanced by incorporating this insight.	4.1) Prioritise investment in evidence-based and innovative theory-driven tobacco control measures, preferably behaviourally informed and ensure our knowledge of research findings and the evidence base remains up to date, and continuously informs the work to control tobacco in Suffolk. 4.2) Exploring ways to expand the provision of specialist stop smoking programmes tailored to priority groups. Including supporting the TDTP pathways into the community stop smoking provisions. 4.3) Scoping opportunities to provide the health and social care workforce with training on brief interventions and create practitioner networks. 4.4) Working with partners to increase outreach efforts and community involvement in designing initiatives. • Consider offering cessation services for people who vape, and for young people. There is no current service to support people who vape who wish to quit [source: FGS webinar 2, January 2024). • The novel Healthwatch interviews conducted for this HNA influenced some respondents to think about new quit attempts. There is an opportunity here to utilise approaches such as MECC and VBA locally to get more people talking about their experiences of smoking / using tobacco and supporting them to quit.

	• When providing interventions consider what influences smokers to continue smoking, barriers to quitting and work alongside agencies who support people with wider determinants. • Develop a toolkit for stop smoking services that captures the behavioural aspects of smoking to inform a tailored approach to intervention implementation. Use the toolkit to offer tailored and targeted communications and intervention support that leverage suitable intervention functions, geared to heighten self-awareness.
5. Ensure all Suffolk system partners have up to date information about stopping smoking including influences of smoking behaviour and facilitating a desire to stop and the services available to support Suffolk residents. **Why?** It is vital for referring and information sharing organisations have up to date weblinks, literature and referral pathways to the Suffolk stop smoking service and information, Feel Good Suffolk. The Healthwatch report and behavioural systems map demonstrated the importance of leveraging other factors to facilitate a desire to quit (i.e., motivation and emotion) to reach wider audiences. As such, Suffolk system partners would benefit from incorporating these wider behavioural influences and importantly, how to address these influences, into their work.	• Ensure that referring and information sharing organisations have up to date weblinks, literature and referral pathways to the Suffolk stop smoking services and information, Feel Good Suffolk. • Ensure that service information considers health literacy and low literacy level audiences. • Explore how these interventions address the specific influences that might challenge these groups to quit smoking? Explore innovative solutions if the interventions are not addressing influences, as well as tighten our understanding of their effectiveness. • Because a desire to stop smoking varies, and is key in driving behaviour change, system partners' behavioural support and media programmes should broaden the narratives they present directly addressing any elements that would undermine a desire and capitalise on elements known to prompt a desire to change behaviour.
6. Strengthen prevention efforts and de-normalise smoking. **Why?**	**Implement universal and targeted campaigns.** • Use behavioural systems mapping to inform campaigns. • To encourage stopping smoking including the mental health benefits, swap to stop • Initiatives to prevention smoking initiation

Universal and targeted campaigns that encourage stopping smoking, swap to stop, and initiatives to prevent smoking initiation may help to reduce smoking prevalence in Suffolk. The Healthwatch report and behavioural systems map indicated how smoking behaviour – particularly relapse - is strengthened the relationship between smoking, stress, and coping. Prevention efforts would benefit by addressing these relationships.	• Using campaigns or interactions with current smokers to discourage smoking around their young people. Focus on parental smoking as this is a significant predictor of children and young people smoking initiation. • Work with target groups to create appropriate campaigns. • Work with Suffolk Fire and Rescue Service on an awareness campaign of fires because of smoking materials (see incidents related to smoking). **Create smokefree environments.** • Work alongside Suffolk workplace initiatives to promote and support smokefree workplaces. • Work with local authority planning to scope the creation of more smoke-free environments (such as playgrounds, parks, school zones and smoke free events) **Address behavioural relationships.** • Because stressful life events maintain current smoking AND are implicit in lapse/relapse of quits, stress management should form an important aspect of relapse prevention as part of behavioural support for stopping smoking. • Similarly, behavioural support should tackle smokers' beliefs about smoking to reduce the likelihood of relapse. • Stress management courses for current smokers could provide an opportunity to access current smokers and provide them with useful skills / knowledge which could attenuate their psychological reliance on smoking.
7. Promote vaping as a safer alternative for adult smokers who are trying to quit. Why? This is aligned with the Chief Medical Officer's advice from 2023. Using vapes as a quitting tool may be helpful for addicted smokers.	• Synchronise and disseminate public health messaging across the system on the relative safety of vaping compared to smoking working with local authority partners, stop smoking service, ICBs, INTs, Alliances, VCSE, business and communities. Messaging should follow a recommended framework for behaviour change (e.g., EAST). • Media campaigns should encompass a broad range of motivations associated with the switch to vaping.

It is recognised that the internal behaviour mapping work undertaken for this HNA found views on vaping as a stop smoking tool were mixed. Therefore, a personalised approach to preferred quit methods needs to be adopted wherever possible. The Healthwatch and behavioural systems map demonstrated how multiple biases shape the use of NRTs and vapes, as well as various opportunity and capability elements that challenge the switch to and exit from vaping – warranting a more nuanced approach in promoting vaping as a safe alternative for adult smokers.	• Aspects of vaping – e.g., smoker's cough, use of disposable vapes – should feature in any education or media campaigns. • Support healthcare providers in recommending vaping for smoking cessation and promote the Swap to Stop service when appropriate. • Ensure that up to date information on dual use (vaping and smoking tobacco) is shared with current studies showing that dual use is as harmful as the exclusive use of cigarettes. • With disposable vapes likely to be banned in England, offer support for disadvantaged groups of smokers, including those who are detained and have dexterity issues and learning difficulties in using reusable vapes, or find alternatives that suit their needs. • Behavioural support programmes should explore capability and motivation elements to facilitate the entry into vaping and facilitate the exit from vaping by being cognizant of the capability, opportunity and motivation barriers that vaping presents. • Acknowledge and address the high level of dependency on vape people can feel when they have when they switch to vape and recognise this can be a barrier to people switching (see stakeholder engagement)
8. Ensure that service provision and local strategies meet a high standard in line with national policies and guidance. **Why?** Continuing to ensure alignment to key local strategic plans and service provision with national guidance will provide a more robust and coherent local stop smoking service.	• Build tobacco control into the strategies and policy of partners in health, social care, district, and boroughs and the VCFSE. • Ensure services, programmes and projects follow NICE and NCSCT guidance on effective stop smoking interventions and service delivery. Where possible use the Standard Treatment Programme Grade A standard with a minimum of six contacts (weekly or bi-weekly) delivered over 6 to 12 weeks, in person or via telephone or video link, from a trained stop smoking practitioner. At least 5% of the smoking population should receive a stop smoking intervention delivered by an NCSCT certified stop smoking practitioner. Services should achieve a minimum 35% quit rate. Include CO monitoring when possible. • Support the implementation of the Tobacco and Vape Bill and "Swap to Stop" scheme.

	• Support the NHS CORE20PLUS5 approach to reducing health inequalities. • Collaborate with enforcement efforts to tackle illicit tobacco and vape product trade. • Primary care (GPs) should ask all their patients about their smoking status and refer to stop smoking services where appropriate. • Ensure GP practices with the highest level of smokers are targeted with stop smoking initiatives and provide an in-house stop smoking service. • Encourage a smoking cessation champion within each primary care setting including Pharmacy. • Consider equipping pharmacies with CO monitors to enable remote delivery of support. • Encourage dentists and health and care professionals to have VBA conversations and ensure they have referral pathway information. • Stop smoking services should provide access to a range of stop smoking methods to quit. • Support and encourage GP practices and community pharmacies to participate as this is likely to increase the number of people trying to quit.
9. Ensure accurate recording and monitoring of smoking and vaping status within the Suffolk population Why? Increasing the completeness of smoking and vaping status in primary care records will enable a more complete understanding of the incidence and prevalence of smoking and vaping in the Suffolk population and ensure future decisions about resources	• Routinely analyse population health data to identify emerging trends and priority areas. • Work with Suffolk GPs to increase the completeness of vaping status in primary care records. • Ensure smoking status of all in-patients in acute and maternity settings is recorded. • Keep up to date with latest research on the long-term health impacts of vaping. • Effectively evaluate the effectiveness of local strategies and initiatives

or policies in relation to smoking and vaping are based on the most robust data possible.	
10. Enhance cross-sector collaboration and community engagement **Why?** Fostering partnerships with various stakeholders like workplaces, schools, and community groups will increase the visibility of stop smoking services.	• Foster partnerships with various stakeholders like workplaces, schools, and community groups. • Provide community grants and involve residents in designing local smokefree initiatives. • Produce a comprehensive marketing and communication plan to increase the visibility of stop smoking services among professionals including health and social care services, Primary Care, the VCSFE.

Who can help in delivering these recommendations?

Who?	Why?
Public Health and Communities (PH&C) Suffolk And the membership of the Suffolk Tobacco Control Alliance (TCA)	PH&C can help with resources allocation, enhance delivery models, prioritise evidence-based tobacco control measures, and strengthen prevention prioritizing smoking cessation among high prevalence groups, pregnant individuals, and young people. The TCA monitors, develops and delivers tobacco control strategy actions.
Local Stop Smoking Service Feel Good Suffolk	To provide high quality stop smoking service that adheres to the NCSCT and NICE guidance, reducing smoking rates using local knowledge and targeted interventions. De-normalize smoking, promote vaping as a safer alternative for those trying to quit, and enhance cross-sector collaboration.
Healthcare settings include GPs, Pharmacies, hospitals, Dentists, Occupational Therapists, Physiotherapists, Mental Health Professionals, Drug and Alcohol services.	Healthcare providers should support smoking cessation, and/or VBA among high-risk groups, pregnant individuals, and their families. De-normalize smoking, promote vaping as a safer alternative for those trying to quit, and enhance cross-sector collaboration. GPs to work on improving the completeness of smoking and vaping status records.
Education settings (Schools, Colleges, Universities)	Educational institutions can help prevent smoking and vaping among children and young people and support cessation efforts for those who have already started.
VCFSE, local support networks, community organisations, Suffolk County Council and District and Boroughs (housing, social care, CYP, as an employer), social housing associations, DWP	Community organisations have widespread reach into local communities that may not be reached via other routes. Local authorities can support smoking cessation promotion, prevent smoking initiation including children and young people, de-normalize smoking through policy, promote vaping as a safer alternative for those trying to quit and enhance cross-sector collaboration. Provide information on available services to tenants, customers and people using services in de-normalize smoking, upskilling staff in very brief advice conversations and disseminating campaign materials.
Researchers and Academic Institutions	There is an opportunity for local researchers and academic institutions to monitor research efforts, particularly related to vaping status and its impact on smoking cessation and long-term health impacts.
Businesses and business sector support networks	Provide information on available services to employees, de-normalize smoking in the workplace and work with stop smoking services to provide access stop smoking opportunities.

Introduction

The Smoking and Vaping Health Needs Assessment for Suffolk 2024 provides an in-depth look at the latest data, trends, and implications related to smoking and vaping/e-cigarette use across the county. It aims to:

- address a wide-ranging health risks and impacts associated with these behaviours.
- examine national policies, ambitions and trading standard incidents and enforcement.
- analyse national and local data & intelligence.
- identify specific target populations that are priorities for smoking and vaping prevention and cessation efforts.
- incorporate stakeholder engagement findings, a specifically commissioned Healthwatch Suffolk report.
- provide evidence of good practice for smoking cessation services and maps local services already in place
- generate a list of recommendations to support Suffolk's new tobacco control strategic delivery plan and inform commissioning.

Evidence is limited to what is currently available; therefore, most findings refer to smoking (including loose tobacco/rollups) and e-cigarettes/vapes not other tobacco products unless specified. Key definitions can be found in appendix 1.

The health risks of smoking & vaping/e-cigarettes

With the vast amount of strong evidence documenting the physical health risks of smoking, this section briefly summarises the key harms of smoking while examining in more depth the growing body of research on the physical health implications of vaping and the mental health implications of both smoking and vaping.

Physical health implications of smoking

Smoking tobacco is one of the biggest causes of death and illness in the UK, it harms nearly every organ of the body. Smoking increases the risk of developing more than 50 serious health conditions. Some may be fatal; others can cause irreversible long-term damage to health[1], some examples are provided below:

- Smoking causes around 7 out of every 10 cases of lung cancer (70%). It also causes cancer in many other parts of the body[1], including the mouth, throat, voice box (larynx), oesophagus (the tube between the mouth and stomach), bladder, bowel, cervix, kidney, liver, stomach and pancreas.
- Smoking damages the heart and blood circulation, increasing the risk of developing conditions such as coronary heart disease, heart attack, stroke, peripheral vascular disease (damaged blood vessels) and cerebrovascular disease (damaged arteries that supply blood to the brain)[1].
- Smoking also damages the lungs, leading to conditions such as chronic obstructive pulmonary disease (COPD), which incorporates bronchitis and emphysema[1].
- Smoking can also worsen or prolong symptoms of respiratory conditions such as asthma, or respiratory tract infections such as the common cold[1].
- Smoking can reduce fertility in both men and women. In men, smoking can cause erectile dysfunction (impotence) because it limits the blood supply to the penis[1].
- Smoking can make it harder to recover from surgery[1].
- Smoking can lead to tooth staining, gum disease, tooth loss, and in more severe cases mouth cancer[2].

Secondhand smoke

Secondhand smoke (SHS), also referred to as 'passive smoking,' can increase the risk of getting the same health conditions as smokers. SHS contains more than 4,000 irritants, toxins, and cancer-causing substances. Most SHS is invisible and odourless, so no matter how careful an individual thinks they have been, people around the smoker still breathe in the harmful poisons. For example, if an individual has never smoked but their partner smokes, the individual's risk of developing lung cancer increases by about a quarter[1].

Babies and children are particularly vulnerable to the effects of SHS. Children who live in a household where at least one person smokes are more likely to develop asthma, chest infections (such as pneumonia and bronchitis), meningitis, ear infections, and coughs and colds[3]. Babies who are exposed to SHS are also at increased risk of sudden infant death syndrome (SIDS), sometimes referred to as cot death, and an ear infection called glue ear[1].

Physical health implications of vaping/e-cigarettes

Vapes and e-cigarettes are still a relatively new product, so the evidence behind how these products impact health is limited. Many studies show that vaping is far less harmful than smoking. Switching from smoking to vaping or dual use appears to reduce levels of biomarkers of potential harm significantly[4]. Therefore, alternative nicotine delivery devices such as vaping products can play a vital role in reducing the huge health burden caused by cigarette smoking.

However, vaping is not risk free, particularly for people who have never smoked. In 2021 survey data from England found that most young adults who vape (around 87%) use vaping products that contain nicotine[5]. Although, in general, vaping products have less than 20mg/mL nicotine e-liquids[6], research has shown that vaping may still result in symptoms of nicotine dependency[7].

Isolating the health effects of nicotine in vaping in human studies is complex. In general, this is done by assessing specific biomarkers in humans. One biomarker, pulse wave velocity (which measures blood pressure pulse through an artery or arteries), did seem to be affected by nicotine in vaping products, at least in acute exposure studies. This suggests that vaping with nicotine may have an impact on heart and lung function. Therefore, chronic usage may lead to long-term adverse health effects[8].

The Office for Health Improvement & Disparities (OHID) published an evidence update on Nicotine Vaping in England in September 2022[6]. Overall, the review showed that compared to smoking using vaping products leads to a reduction in biomarkers of toxicant exposure associated with cigarette smoking. However, the degree of any residual risk remains unclear, mainly because of the lack of comparisons between long-term former smokers who do and do not vape or comparisons with those who have never smoked or vaped. The review examined the health risks of nicotine vaping biomarkers, results are presented in appendix 2. The review also highlighted the potential risk of vaping in relation to specific diseases including cancer, respiratory and cardiovascular diseases, these are discussed in further detail below.

Cancers

Translating findings from preclinical vaping studies in cells, animals, or rodent models to potential cancer risks in humans comes with significant challenges. Many of these studies use acute or concentrated exposures over short periods, making it difficult to know if similar risk pathways would emerge under real-world vaping conditions over time. Additionally, the considerable variations in vaping behaviours, devices, e-liquids, and exposure patterns further complicate extrapolating results to humans.

While limited by these factors, the OHID report identified a growing (but modest) amount of literature on how vaping may impact cancer risk in humans[6]. Key findings include:

- vaping may negatively impact cancer treatment viability for those managing the disease.
- vaping may trigger alterations in gene expression, but at a lower extent than seen from exposure to tobacco smoke.
- Compared to cigarette smoking, vaping generally leads to lower exposure to many harmful carcinogens (substances that may increase you chance of cancer).

Furthermore, in March 2024, University College London (UCL) published a study in cancer research analysing the epigenetic effects of tobacco and e-cigarettes, to investigate the impact on cells that are directly exposed to tobacco (e.g. in the mouth) and those that are not directly exposed (e.g. in blood or cervical cells)[9]. The researchers found that e-cigarette users exhibited some similar epigenetic changes in buccal cells as smokers, and these changes are associated with future lung cancer development in smokers. However, more research is needed to investigate whether these features could be used to individually predict cancer in smokers and e-cigarette users.

Respiratory diseases

The OHID report identified conclusive evidence that under typical use conditions, acute exposure (from single use to 7 days) and short to medium exposure (from 8 days to 12 months) to most potential respiratory toxicants from vaping is significantly lower compared with smoking tobacco cigarettes. For respiratory toxicants that

were assessed at long-term exposure (more than 12 months), the biomarkers (a measure of what is happening in a cell or an organism) of exposure are lower for vaping than smoking.

Evidence on biomarkers of potential harm relevant to multiple diseases was mixed. This indicates there was insufficient evidence from these biomarkers of potential harm on whether vaping product use is associated with respiratory disease, such as asthma or chronic obstructive pulmonary disease (COPD), in humans.

Cardiovascular diseases

The extent to which vaping presents a risk for cardiovascular health remains uncertain. Based on the toxicant profile in vaping products and aerosols, the OHID review found that the risk is expected to be much less than that of cigarette smoking[6]. Key findings include:

- Studies of low-density lipoprotein (LDL) cholesterol showed no differences after acute and short-to-medium use of vaping products, smoking, or non-use. LDL cholesterol is sometimes described as 'bad cholesterol' as it makes heart problems or a stroke more likely.
- Similar findings were seen for high-density lipoprotein (HDL) cholesterol (or 'good cholesterol'), except among large-scale samples of non-users where HDL levels were significantly higher than among vapers and smokers.
- Vaping increased heart rate less than smoking immediately after use.
- Heart rate after short exposure to vaping was similar to heart rate after not using tobacco or nicotine products.
- There was no difference in heart rate after nicotine and non-nicotine vaping. Any differences may vary with devices, liquids and puffing behaviours influencing the amount of nicotine delivered.
- Comparing longer-term changes in heart rate, people who vaped had lower heart rate than people who smoked when the groups were mutually exclusive (people who vaped did not also smoke).
- Compared with people who did not vape or smoke, heart rate among people who vaped was lower in a meta-analysis of cross-sectional studies but higher in another cross-sectional study.
- One longer-term study reported the same level of change in heart rate for smokers who started using nicotine or non-nicotine vaping products.
- A meta-analysis of cross-sectional studies where participants had had longer exposure to vaping (at least 3 months or one year) found that people who vaped (researchers presumed these were mostly former smokers) had lower blood pressure than people who smoked. There was no difference between people who vaped and people who did not vape or smoke.

Oral health

The OHID review concluded that vaping would be detrimental to oral or dental health among people who have never vaped or smoked but would likely be beneficial for smokers switching.

Secondhand exposure

The OHID review identified six studies assessing secondhand exposure to vaping products, using a variety of biomarkers, none from the UK. The level of exposure varied greatly from people at home to people attending an indoor vaping convention. Short exposures to second-hand vaping did not result in detectable changes in levels of nicotine, Volatile organic compounds (VOCs) or Tobacco-Specific Nitrosamines (TSNAs). However, longer exposures during heavy sustained vaping were associated with significant increases in nicotine or potential toxicant metabolites[6].

Poisonings, fires, and explosions

In 2021, the National Poisons Information Service (NPIS) reported that they had received 187 vaping product enquiries out of a total of 39,594 telephone enquiries. Of these, 82 involved children aged 5 years or younger. This equates to at least one telephone enquiry every other day involving a healthcare professional managing someone who has apparently been exposed to vaping products.

Two case reports of poisoning from vaping products in the UK were identified, both intentional. One described a 32-year-old man who died after he was reported to have deliberatively drunk approximately 20mL from a

bottle containing 72mg/mL nicotine (reported total ingestion of 1440 mg nicotine). He also had signs of alcohol toxicity, though the coroner attributed the primary cause of death to nicotine toxicity[10]. The second case study describes a 29-year-old woman who deliberately swallowed two 1.5 mL e-liquid cartridges containing 27mg of nicotine per cartridge. The only clinical feature was sinus tachycardia on an electrocardiogram, believed to be due to anxiety rather than leakage from the nicotine cartridge, however plasma levels of nicotine were not tested. She was observed for 72 hours, with no further ill effects and one cartridge was expelled after administering laxatives and metoclopramide[11].

In non-UK poisonings, according to data from a 2020 annual report by the American Association of Poison Control Centres' National Poison Data System, one person died from vaping product use (no details were given of the circumstances). In 20 studies from international poisons and surveillance centres and case reports identified, most participants were young children who accidentally swallowed e-liquids. Almost all children recovered, although there were 2 deaths among the children who were accidentally exposed to e-liquid. Where exposure was intentional or unknown, there were reports of 16 deaths (outside the UK).

Between January 2017 and October 2021, the London Fire Brigade reported that there were 5,706 fires caused by cigarettes and cigarette lighters. This compared to 15 fires caused by vaping products. No fire related injuries or deaths were reported from vaping related fires, compared with 676 injuries and 46 deaths from cigarette related fires. These findings are similar to those discussed in the 2018 report.

Exploding vaping products can cause severe burns and injuries that require intensive and prolonged medical treatment, especially when they explode in users' hands, pockets, or mouths. Incidents appear to be serious but very rare. 2 case reports involving 4 people in the UK were identified. One involved an explosion in the mouth while vaping, the other 3 involved explosions when the vaping product was being carried in trouser pockets. No deaths were reported. There were 23 reports identified outside the UK, from case reports and series or data from burn and surveillance of injury centers. Carrying the vaping product in a trouser pocket was again the most common cause of explosions. One death was reported[6].

Illicit vapes/e-cigarettes

Manufacturers must follow regulations on ingredients, packaging, and marketing - and all e-cigarettes and e-liquids must be registered with the Medicine and Health Care Products Regulatory Agency (MHRA). Illicit, or non-compliant, vapes are vaping products that do not fulfil the criteria set out in The Tobacco and Related Products Regulations (TRPRs), and/or are deemed unsafe under the General Products Safety Regulations (GPSRs). The majority of the TRPRs are enforced by local authority Trading Standards officers. These officers have the power to seize illegal products.

Based on test purchasing, around 1 in 3 vape products may be non-compliant- this may include having the wrong health warning, wrong tank size, a higher concentration of nicotine, containing cannabidiol (CBD), incorrect labelling- or all the above. In November 2023, the government stated that "over 2 million illicit vapes" had been seized across England by Trading Standards from 2022 to 2023.

The sale and use of illicit e-cigarettes, which do not conform to the necessary product standards, place users at risk. In 2023, the BBC reported on used vapes gathered at Baxter College in Kidderminster were tested in a laboratory. Most were illegal and had not gone through any kind of testing before being sold in the UK. Results found that children using them could inhale more than twice the daily safe amount of lead, and nine times the safe amount of nickel. The metals were thought to come from the heating element - but the tests showed they were in the e-liquid itself. The lab tests also found compounds called carbonyls - which break down, when the e-liquid heats up, into chemicals such as formaldehyde and acetaldehyde, also found in cigarette smoke - at 10 times the level in legal vapes. Some even had more than cigarettes[12].

Although, the Chartered Trading Standards Institute (CTSI) released a statement in March 2023 stating, "there are no definitive health risks to using non-compliant vapes". The MHRA still strongly advises consumers not to use them as the true content is unknown, along with any possible health risks.

The UK Addiction Treatment Centers discusses some of the harmful ingredients potentially found in illegal vapes, bought outside of licensed sellers these include:

- **Pulegone:** a flavouring in some mint and menthol e-cigarettes/vapes. Pulegone is a known carcinogen, causing cancer of the urinary bladder and liver at high doses[13].
- **Diacetyl, Acetoin, Pentanedione:** Diacetyl is linked to bronchiolitis obliterans (inflamed airways- also known as "popcorn lung"). Acetoin is less toxic but transforms into diacetyl over time, while acetyl propionyl (pentanedione) leads to respiratory inflammation and lung damage[14].
- **Vitamin E acetate:** Vitamin E acetate, used illicitly to mix THC in vape juice. This additive is linked to e-cigarette vaping-associated lung injuries (EVALI)[14].

Dual use

Some people try to cut back on smoking cigarettes or work toward quitting smoking completely by using e-cigarettes/vapes in addition to regular cigarettes. This is called "dual use." Dual use is not an effective way to safeguard health. A systematic review published in the International Journal of Environmental Research and Public Health, 2022, aimed to identify the health effects of real-world dual use of e-cigarettes and cigarettes compared to the health effects of cigarettes. Most prospective studies found dual use to be at least as harmful as the exclusive use of cigarettes. Most of the best available cross-sectional studies found dual use associated with the same and, in several studies, significantly higher risk of self-reported symptoms/disease than in exclusive cigarette smoking. The intensity of cigarette smoking seems associated with worse health. However, due to the predominance of cross-sectional studies and the methodological weaknesses there is low certainty in the evidence available[15].

Mental health implications of smoking & vapes/e-cigarettes

There is a strong association between smoking and mental health conditions. Smoking rates among people with a mental health condition are significantly higher than in the general population and this association becomes stronger relative to the severity of the mental health condition, with the highest levels of smoking found in psychiatric in-patients[16,17].

Most people start to smoke before showing signs of depression, so it is unclear whether smoking leads to depression or depression encourages people to start smoking. It is most likely that there is a complex relationship between the two. However, it is known that adults with depression are twice as likely to smoke as adults without depression[18]. People with depression can also have particular difficulty when they try to stop smoking and have more severe withdrawal symptoms.

People with schizophrenia are three times more likely to smoke than other people and tend to smoke more heavily. It's likely this is because people with schizophrenia use smoking to control or manage some of the symptoms associated with their illness and reduce some of the side effects of their medication[18]. Research has shown smoking may increase the risk of developing schizophrenia. However, further research is needed to fully understand how the two are linked[19].

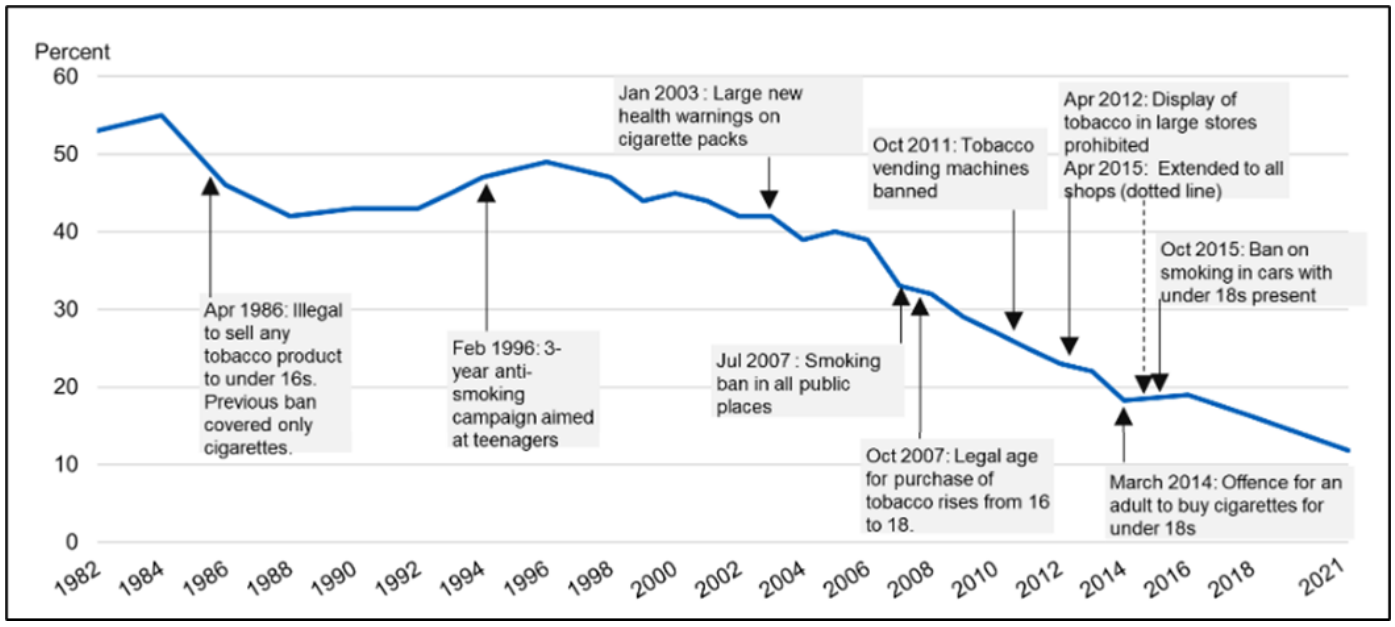
Some people smoke as 'self-medication' to ease feelings of stress. However, research shows that smoking increases anxiety and tension. Nicotine (found in both cigarettes and vapes) creates an immediate sense of relaxation, so people who smoke or use e-cigarettes/vapes may believe it reduces stress and anxiety. This feeling is temporary and soon gives way to withdrawal symptoms and increased cravings. Smoking or use of e-cigarette/vapes reduces withdrawal symptoms but doesn't reduce anxiety or deal with the reasons someone may feel this way[18].

Nicotine stimulates the release of the chemical dopamine in the brain. Dopamine is involved in triggering positive feelings. It is often found to be low in people with depression, who may then use smoking or e-cigarettes/vapes to temporarily increase their dopamine supply. However, this encourages the brain to switch off its mechanism for making dopamine, so in the long term, the supply decreases, which in turn prompts people to smoke or use e-cigarettes/vapes more[18].

National policy

The United Kingdom has implemented national policies and initiatives to address the public health burden caused by smoking and vaping. Stop smoking policy initiatives have led to a steady decline in pupil smoking since 1996, when 49% of pupils had smoked at least once. Figure 1 shows the percentage of pupils who have ever smoked between 1982 and 2021. Results highlights the beneficial association between stop smoking policy initiatives and prevalence of pupils who have ever smoked.

Figure 1: The prevalence of UK pupils (aged 11 to 15 years) who have ever smoked between 1982 and 2021, correlated with stop smoking policy initiatives



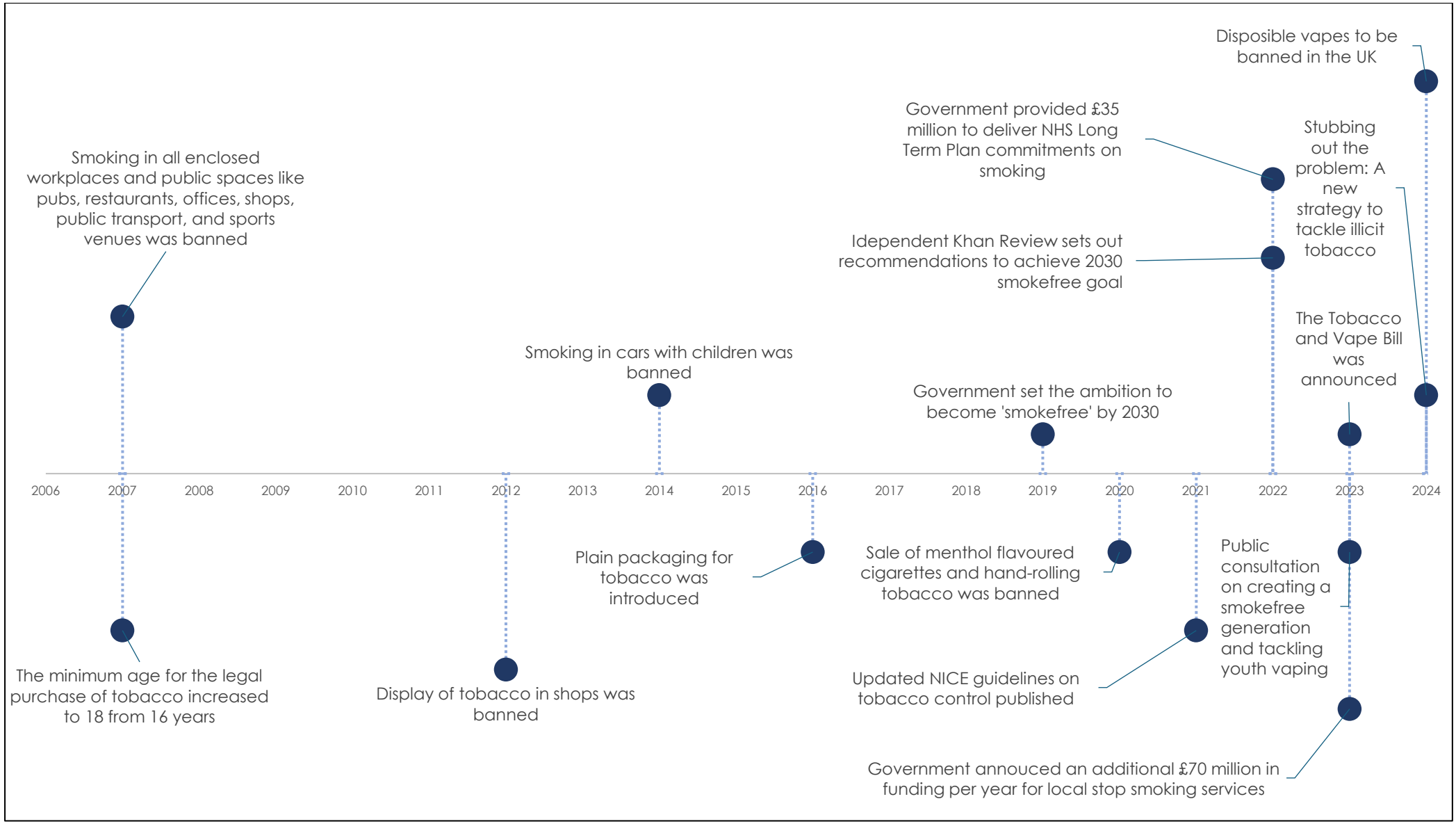
Source: NHS Digital

Figure 2 presents a timeline outlining all action on smoking and vaping control from 2006 to 2024. This includes:

- The minimum age for the legal purchase of tobacco increased to 18 from 16 years (2007)[20]
- A ban on smoking in all enclosed workplaces and public spaces (July 2007)[21]
- A ban on the display of tobacco in shops (2012)[22]
- A ban on smoking in cars with children (2014)[23]
- Mandatory plain packaging for tobacco (2016)[24]
- Government set the ambition for England to become 'smokefree' by 2030 (2019)[25]
- Ban on the sale of menthol flavoured cigarettes and hand-rolling tobacco (May 2020)[26]
- Updated NICE guidelines on tobacco control published (2021)[27]
- Independent Khan Review sets out recommendations to achieve 2030 smokefree goal (2022)[28]
- UK Government provided £35 million to deliver on the NHS Long Term Plan's commitments on smoking (2022)[29]. The Tobacco Dependency Treatment Programme commitments included:
  - making a significant new contribution to a smokefree society by supporting people in contact with inpatient NHS hospital services to quit based on a proven model implemented in Canada and Manchester[30]. With the hope that, by 2023/24, all people admitted to hospital who smoke will be offered NHS-funded stop smoking treatment services.
  - Adapting the model implemented in Canada and Manchester[30] for expectant mothers, and their partners, with a new smokefree pregnancy pathway including focused sessions and treatment.
  - Introduce a new universal smoking cessation offer as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services, including the option to switch to e-cigarettes while in inpatient settings[31].
  - Stopping the start: our new plan to create a smokefree generation was published (2023). This outlined:
    - Government announced an additional £70 million in funding per year for local stop smoking services (2023)[32]

    - Public consultation on creating a smokefree generation and tackling youth vaping (2023)[33]
- The Tobacco and Vape Bill was announced (2023)[32].
- Stubbing out the problem: A new strategy to tackle illicit tobacco published (2024)[34]
- Disposable vapes ban in the UK announced (2024)[35]

Figure 2: Timeline outlining all action on smoking and vaping control from 2006 to 2024



The smokefree 2030 ambition for England

In 2019, the government published a green paper on preventative health titled Advancing our health: prevention in the 2020s. The paper emphasises a proactive, predictive, and personalised approach to prevention, leveraging new technologies, data, and a collaborative effort across government, healthcare, and individuals. The paper announced the ambition for England to become 'smokefree' by 2030- achieved when adult smoking prevalence falls to 5% or less[36].

The government commissioned Javed Khan, to carry out an independent review into the ambitions to make England smokefree by 2030. In June 2022, Khan published The Khan review: making smoking obsolete. The review showed that **"without further action, England will miss the smokefree 2030 target by at least 7 years, and the poorest areas in society will not meet it until 2044"**[28].

The review set out a package of 15 recommendations aimed at supporting the 2030 ambition. This included four "critical must dos" for the Government:

- increasing investment in smokefree 2030 policies
- increasing the age of sale of tobacco by one year every year
- promoting vaping as a smoking cessation tool
- improving the prevention of ill health by offering smokers advice and support to quit at every interaction within the NHS[28].

In addition the Khan review also highlighted a need to support the commissioning of incentive schemes to support smokefree pregnancies[28]. In April 2023, the Government announced that all pregnant women who smoke will be offered financial incentives in the form of vouchers alongside behavioural support by the end of 2024.

From this, the Department of Health and Social Care (DHSC) published a policy paper titled Stopping the start: our new plan to create a smokefree generation
In this the government committed to funding several initiatives to improve smoking cessation support, this included[29]:

- an additional £70 million per year to support local authority-led stop smoking services (SSS) - more than doubling current spend from £68 million per year (to a total of £138 million) and supporting around 360,000 people to set a quit date each year
- an additional £5 million this year and then £15 million per year after to fund new national anti-smoking campaigns - a substantial uplift on current spend
- up to £45 million over 2 years to roll out our new national 'Swap to Stop' scheme - supporting 1 million smokers to swap cigarettes for vapes
- up to £10 million over 2 years to provide evidence-based financial incentives to support all pregnant smokers to quit

Following this, in November 2023 the Tobacco and Vapes Bill was announced in the King's Speech[32]. The Tobacco and Vapes Bill will:

1. Create the first ever smokefree generation by:
    - making it an offence to sell tobacco products to those born on or after 1 January 2009, thereby phasing out the sale of tobacco products, while not stopping anyone who currently legally smokes from being able to do so. This will mean anyone who turns 15 or younger in 2024 will never legally be sold tobacco products.
    - amending existing legislation to make it an offence for anyone over 18 to purchase tobacco products on behalf of those born on or after 1 January 2009 (proxy purchasing)
    - supporting the enforcement of the new measures by requiring retailers to update the current age of sale notices (or warning statements) to read: 'It is illegal to sell tobacco products to anyone born on or after 1 January 2009'
2. Reduce the appeal and availability of vaping products by:
    - providing powers for ministers to regulate:

    - the flavours and contents of vaping products
    - the packaging and product presentation of vaping products
    - point of sale displays of vaping products
- making it an offence to sell non-nicotine vaping products to someone who is under 18 in England, Wales, and Northern Ireland. Scotland already has this in place.
- introducing a ban on the free distribution of vaping products to under 18s in England and Wales and provide Northern Ireland with a power to also introduce a ban. Scotland already has these powers.
- providing ministers with powers to extend the measures outlined above for vaping products to other nicotine products such as nicotine pouches.

3. Strengthen enforcement of underage sales of tobacco and vapes by:
    - providing enforcement authorities in England and Wales with the power to issue Fixed Penalty Notices of £100 for the underage sale of tobacco products and vaping products.
    - continuing to apply existing penalties to give Trading Standards the ability to escalate to a level 4 fine (up to £2,500), as well as restricted premises orders and restricted sales orders for repeat offenders in England and Wales

The Bill will extend to England and Wales. However, the government is working closely with the Devolved Administrations to understand their legislative intentions following the consultation and to support them should they choose to implement these measures.

UK-wide public consultation on the smoking and vape/e-cigarette measures

Following this, the DHSC launched an eight-week UK-wide public consultation on the smoking and vaping measures[33]. On the 29th of January 2024 the government responded to the UK-wide public consultation on smoking and vaping. The response outlined that disposable vapes will be banned in the UK as part of plans to tackle the rise in youth vaping. New powers will be introduced to restrict flavours which are specifically marketed at children and ensure that manufacturers produce plainer, less visually appealing packaging. The powers will also allow government to change how vapes are displayed in shops, moving them out of sight of children and away from products that appeal to them, like sweets[35].

Trading standards: Stubbing out the problem

HMRC estimates that the illicit market in tobacco duty and related VAT was £2.8 billion in 2021 to 2022. The proceeds of this crime fund the smuggling of weapons, drugs, and even human beings across the globe. Therefore, professionals must tackle organised criminal groups as firmly as we aim to reduce the harms of smoking itself[34].

HMRC launched its first strategy to tackle illicit tobacco in 2000. This, and consequent strategies with Border Force, have reduced the estimated duty gap for cigarettes by a third (from 16.9% in 2005 to 11% in 2021 to 2022) and for hand-rolling tobacco by a half (from 65.2% to 33.5% over the same period). The last strategy was published in 2015 driving forward new legislation, sanctions, controls, and operations to tackle the illicit trade[34].

At the beginning of March 2024 a new strategy was published titled Stubbing out the problem: A new strategy to tackle illicit tobacco. The new strategy will target loopholes at all stages of the supply chain. The strategy:

- sets out our new root and branch approach - which targets the demand for illicit trade (the consumers that criminals seek to exploit) as well as the supply (the criminals themselves)
- is supported by over £100 million new funding over the next 5 years to boost HMRC and Border Force enforcement capability.
- establishes a new, cross-government Illicit Tobacco Taskforce – combining the operational, investigative and intelligence expertise of various agencies, and enhancing our ability to disrupt organised crime.

Smoking: data & intelligence

The national picture

In September 2023, ONS published findings regarding Adult smoking habits in the UK: 2022. Key findings are as follows[37]:

- In 2022, 12.9% of UK adults smoked, equating to over 6 million people
- Smoking rates are higher among men (14.6%) than women (11.2%)
- Highest smoking rates were shown among 25-34 year-olds (16.3%) and lowest among over 65s (8.3%)
- The largest decline in smoking prevalence was seen in 18-24 year-olds (from 25.7% in 2011 to 11.6% in 2022)
- Smoking is the leading cause of health inequalities and accounts for half of the difference in life expectancy between the most and least affluent communities in England. Smoking is associated with most indicators of disadvantage, for example:
    - There are much higher smoking rates among low income and routine/manual worker groups compared to managerial/professional groups.
    - 27.2% of those with no qualification smoked compared to 6.5% of those with a degree.
    - National data indicates that people reporting fair/ bad or very bad health had statistically significantly worse smoking prevalence rates compared to England[38].
    - When looking at smoking prevalence in relation to religious belief, people that reported 'none' in relation to religious belief had statistically significantly worse smoking prevalence rates compared to the England average[39].
    - When looking at smoking prevalence in relation to relationship status, people that reported ‘cohabiting’ or ‘single’ in relation to relationship status had a statistically significant higher smoking prevalence compared to those who reported “married or civil partnership” and “widowed, divorced or separated”[40].

The local picture

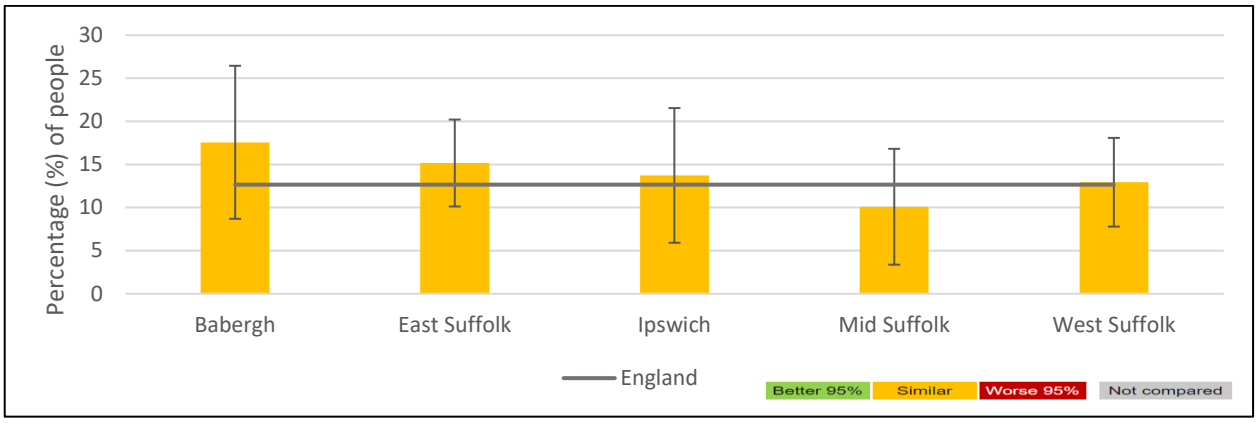
The following sections describes data for Suffolk. Data on smoking at Integrated Care Board (ICB) or sub-ICB level can be found in appendix 3.

Prevalence and trends

The smoking prevalence figures included are from the Annual Population Survey (APS). The APS is the most widely used survey for estimating smoking prevalence due to its large sample size and frequency (around 175,000 people in England per year). The APS is designated as a National Statistic and has provided a consistent time series of data for smoking prevalence[41].

The 2022 Annual Population Survey (APS) highlights that 14% of Suffolk’s adult population, 18 years or over, smoke (~84,900 people), this is statistically similar when compared to the England estimate of 12.7%. The prevalence of smoking among persons 18 years and over, across Suffolk districts, compared to England in 2022, as reported in the APS, are presented in figure 3. Results show that in 2022 all districts across Suffolk had a statistically similar prevalence of smoking in adults aged 18 years and over compared to the England estimate. Babergh had the highest average prevalence of 17.6%, followed by East Suffolk with an average prevalence of 15.2%. Ipswich, West Suffolk, and Mid Suffolk had an average prevalence of 13.7%, 12.9%, and 10.1%, respectively.

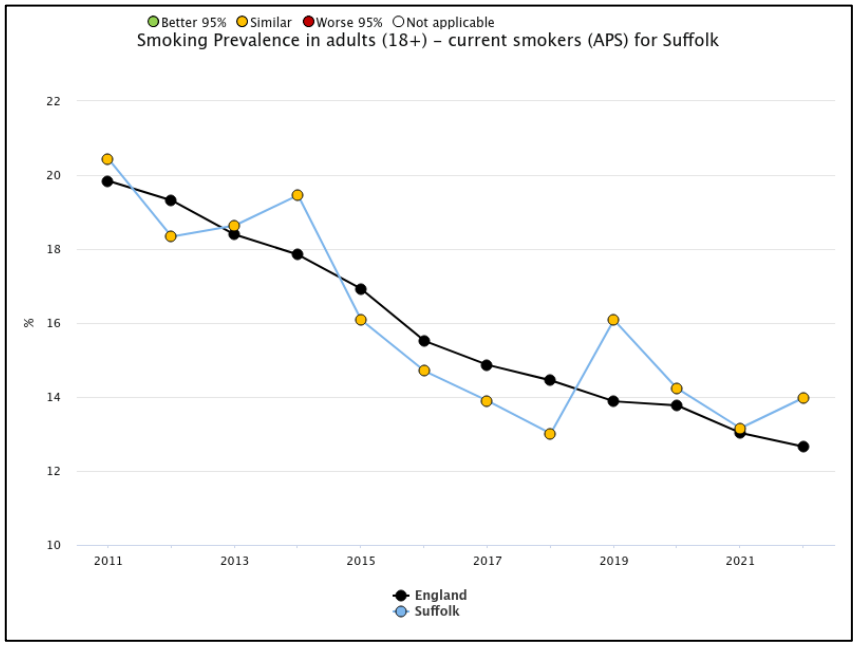
Figure 3: Prevalence of smoking among persons 18 years and over, across Suffolk districts, compared to England averages, APS 2022



Source: Fingertips

Figure 4 shows the Suffolk trend in smoking prevalence among persons 18 years and over between 2011 and 2022, as reported by the APS. Results show that in Suffolk smoking prevalence has decreased by 6.4 percentage points from 20.4% in 2011 to 14.0% in 2022. Similarly, England has seen a decrease of 7.1 percentage points from 19.8% in 2011 to 12.7% in 2022.

Figure 4: Smoking prevalence in adults (18 years and over) as reported by the APS, in Suffolk, compared to England, between 2011 and 2022



Source: Fingertips

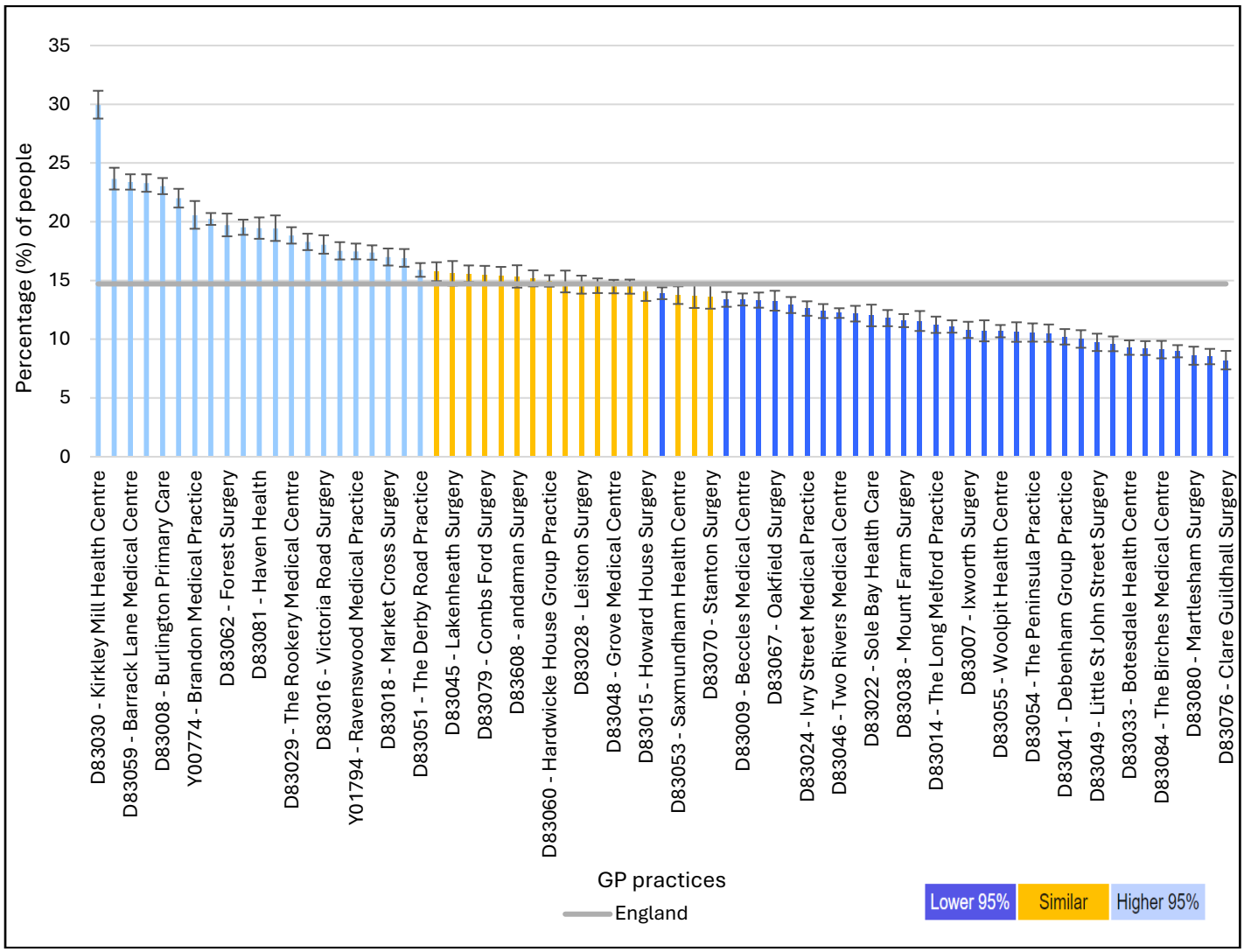
Smoking prevalence is also measured within the NHS Quality Outcomes Framework (QoF). This highlights the number of patients aged 15 years or over who are recorded as current smokers as recorded in patient records by general practitioners.

Figure 5 shows the smoking prevalence as recorded within the QoF for general practices (GPs) across Suffolk, compared to England for 2022/23.

Results show that over 1 in 4 (21 out of the 71, 29.6%) GPs across Suffolk have a statistically significantly higher smoking prevalence compared to the England estimate of 14.7%. Kirkley Mill Health Centre (30.0%), Haworth Drive Surgery (23.7%), Barrack Lane Medical Centre (23.4%), Alexandra & Crestview Surgeries

(23.3%), Burlington Primary Care (23.0%) and High Street Surgery (22.0%), all had smoking prevalence above 20% suggesting that over 1 in 5 of their registered patient's smoke.

Figure 5: Smoking QOF prevalence (15+ yrs.), for General Practices in Suffolk, compared to England, 2022/23



Source: Fingertips

Suffolk smoking demographic

This section analyses data from the Optum Population Health Management Reporting Suite (PHMRS). The PHMRS contains up-to-date data from patients registered to a GP in Suffolk and North East Essex (SNEE) and for Suffolk alliances (West Suffolk Ipswich and East Suffolk). PHMRS joins data from primary care, secondary care, mental health, social care, and other sources into a single dataset, including both activity and cost data. Although the PHMRS is a rich source of data, that has been aggregated so that individuals cannot be identified. It is still under development and not without its constraints. As such, there are factors to be aware of, at the time of data analysis:

- 1-year indicators only provide a static snapshot of: December 2022 – November 2023
- Includes data for people living in Suffolk, under the age of 101 years, registered to a GP practice in Suffolk and North East Essex (SNEE) Integrated Care Board but does not include Waveney or SNEE residents registered to a GP outside of SNEE.
- Dataset is missing data from two GP Surgeries and incomplete data from 3 GP surgeries.
- Includes data for people living in Suffolk registered to a GP practice in Suffolk alliances.

- Data for health and demographic conditions incorporated in this HNA have been selected to provide Suffolk-level context for risk factors identified nationally by Statistics on Smoking (replaced by Statistics on Public Health) and Public mental health and smoking: A framework for action - ASH
- Ethnicity data is currently incomplete (does not include ethnicity data from primary care)
- Data is not included for patients that are deceased.

One indicator was identified regarding smoking prevalence, 'History of smoking – within the past year.' This indicator is defined as the number of patients that have been recorded as a 'smoker' from December 2022-November 2023.

- Patients have been recorded to have at least one of the variables under the Cluster ID LSMOK_COD in the primary care domain reference set.
- Includes an array of Optum derived variables which indicate the patient uses tobacco. Two Optum derived variables included do not directly measure tobacco products:
    - Smokes drugs
    - Smoking free weeks

Table 1 shows the overall population measures for the number of people aged over 15 recorded as having a history smoking (within the past year), for NHS SNEE ICB and combined Ipswich and East Suffolk and West Suffolk alliances level for December 2022 to November 2023. Results show that 63,393 people (7.7% of the population) in SNEE and 40,737 (7.6% of the population) in the Suffolk alliances are recorded as having a history of smoking (in the past year). Smoking prevalence is higher among men than women in both SNEE ICB (50.9% of people with a history of smoking) and Suffolk alliances (51.1% of people with a history of smoking). An average of 7.8% in SNEE and 7.9% in the Suffolk alliances are from ethnic minority groups (compared with 10.5% and 9.9% of the population, respectively).

An additional 182 people for SNEE and 145 people for Suffolk alliances aged 15 and under are recorded as smokers but are excluded from this analysis to ensure fair comparison of health attainment and per person per year (PPPY) between smokers and non-smokers.

Table 1: Overall population measures for the number of people aged over 15 recorded as having a history of smoking (within the past year); December 2022 – November 2023

	SNEE ICB		Suffolk alliances	
	History of smoking (in the past year)	Population average	History of smoking (in the past year)	Population average
Population	63,393	823,739	40,737	538,638
% Male	50.9	49.7	51.1	49.8
% Ethnic Minority (if recorded)	7.8	10.5	7.9	9.9

Source: PHM Dashboard Descriptive Analysis

Table 2 shows people with a recorded history of smoking (within the last year) in the SNEE ICB and Suffolk alliances by age providing a count and percentage of the total population for December 2022- November 2023. Results show that the highest proportion of people with a history of smoking was the 50–59-year-old population for both SNEE ICB (9.9%) and Suffolk alliances (9.6%). This was closely followed by 40–49-year-olds for both SNEE ICB (9.3%) and Suffolk alliances (9.2%), and 60-69 year olds for SNEE ICB (8.8%) and 30-39 year olds for Suffolk alliances (8.5%). The age group with the lowest proportion of individuals recorded as having a history of smoking within the last year was 90 years and older with a prevalence of 1.4% for both SNEE ICB and Suffolk alliances.

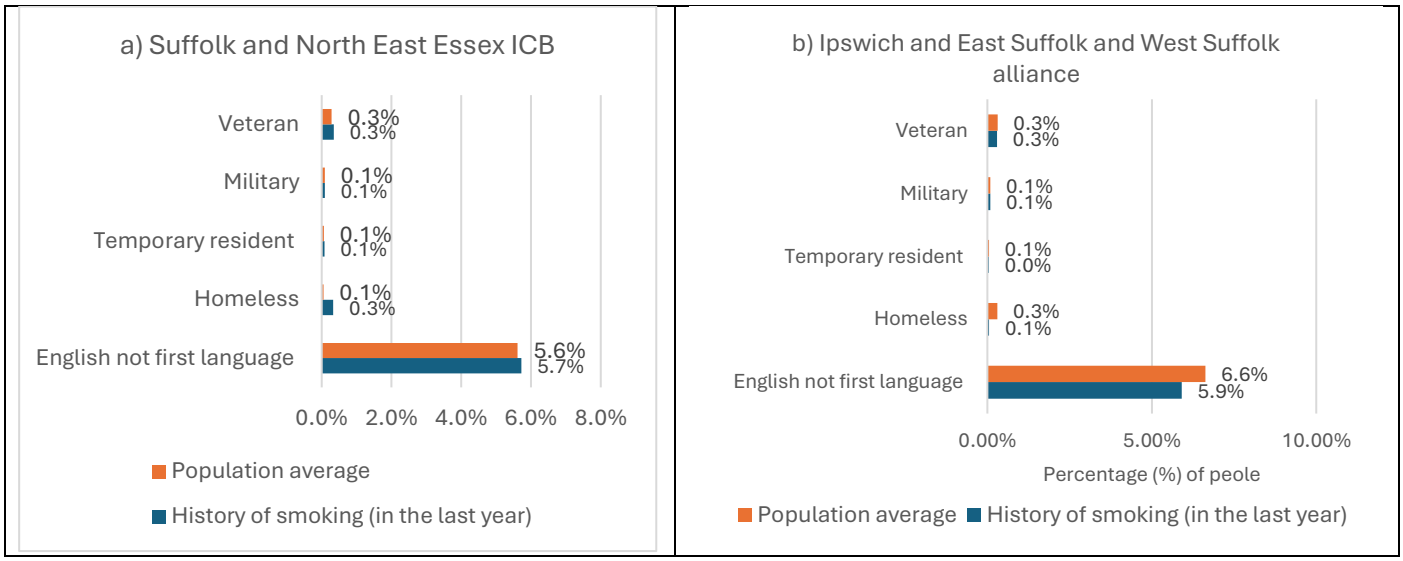
Table 2: People with a recorded history of smoking in the last year in the NHS SNEE population and Suffolk alliances, shown as a count and percentage of total population; December 2022 – November 2023

	SNEE ICB		Suffolk alliances	
	Count	%	Count	%
10-19 years old	1432	2.6	891	2.5
20-29 years old	8478	7.8	5354	7.9
30-39 years old	10554	8.3	6981	8.5
40-49 years old	11084	9.3	7307	9.2
50-59 years old	13249	9.9	8656	9.6
60-69 years old	10293	8.8	6524	8.3
70-79 years old	6268	6.2	3889	5.9
80-89 years old	1184	3.8	1136	3.5
90+ years old	150	1.4	99	1.4

Source: PHM Dashboard Descriptive Analysis

Figure 6 shows the percentage of people within selected demographics with a history of smoking in the last year (where recorded) for both SNEE ICB and Suffolk alliances. The data indicates that English is not the first language for 5.7% of the SNEE population with a history of smoking and 5.9% of the Suffolk alliances population with a history of smoking. 0.4% of people with a history of smoking are either in the military or a veteran for both SNEE ICB and Suffolk alliances. Additionally, in SNEE ICB 0.3% of people with a history of smoking are homeless and 0.1% identified as a temporary resident. This is lower in Suffolk alliances with 0.0% identifying as temporary residents and 0.1% identifying as homeless.

Figure 6: Demographic groups of people aged over 15 recorded as having a history of smoking (within the past year) in a) Suffolk and North East Essex ICB and b) Ipswich and East Suffolk and West Suffolk alliances; data currently unavailable for 1) Eastern Europe 2) Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) population groups; December 2022- November 2023



Source: PHM Dashboard Descriptive Analysis

Table 3 presents the number and percentage of people with a history of smoking living in urban, rural, and coastal areas between December 2022-November 2023. Results show that a higher proportion of people with a history of smoking in the past year for both SNEE (12,603 people [9.8%]) and Suffolk alliances (2,903 people [8.7%]) live in a coastal area. This was followed by urban areas, with 8.1% (32,930 people) having a history of smoking in SNEE and 8.3% (24,254 people) having a history of smoking in Suffolk alliances. Rural

areas had the smallest proportion of the population having a history of smoking recording a prevalence of 6.2% (17,600 people) in SNEE and 6.3% (13,353 people) in Suffolk alliances.

Table 3: The percentage of people over age 15 with a history of smoking (in year) living in urban, rural, and coastal areas; December 2022 – November 2023

	Rural		Urban		Coastal	
	Count	%	Count	%	Count	%
SNEE ICB	17,600	6.2	32,930	8.1	12,603	9.8
Suffolk alliances	13,353	6.3	24,254	8.3	2,903	8.7

Source: PHM Dashboard Inequalities tab

Smoking & ill health

Disability-adjusted life years

The global burden of disease (GBD) study is a systematic, scientific effort to quantify the comparative extent of health loss due to diseases, injuries, and risk factors by age, sex, and geographies for specific points in time[42].

Mortality does not give a complete picture of the burden of disease carried by individuals in different populations. The overall burden of disease is assessed using the disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality (YLLs) and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability (YLDs). One DALY represents the loss of the equivalent of one year of full health[43].

Figure 7 presents a treemap highlighting the disability-adjusted life years (DALYs) attributable to tobacco (including smoking, chewing tobacco and secondhand smoke). The chart is essentially a square pie chart; the size of each box is proportionate to the burden displayed. An interacted version of this treemap can be found on GBD Compare (IHME).

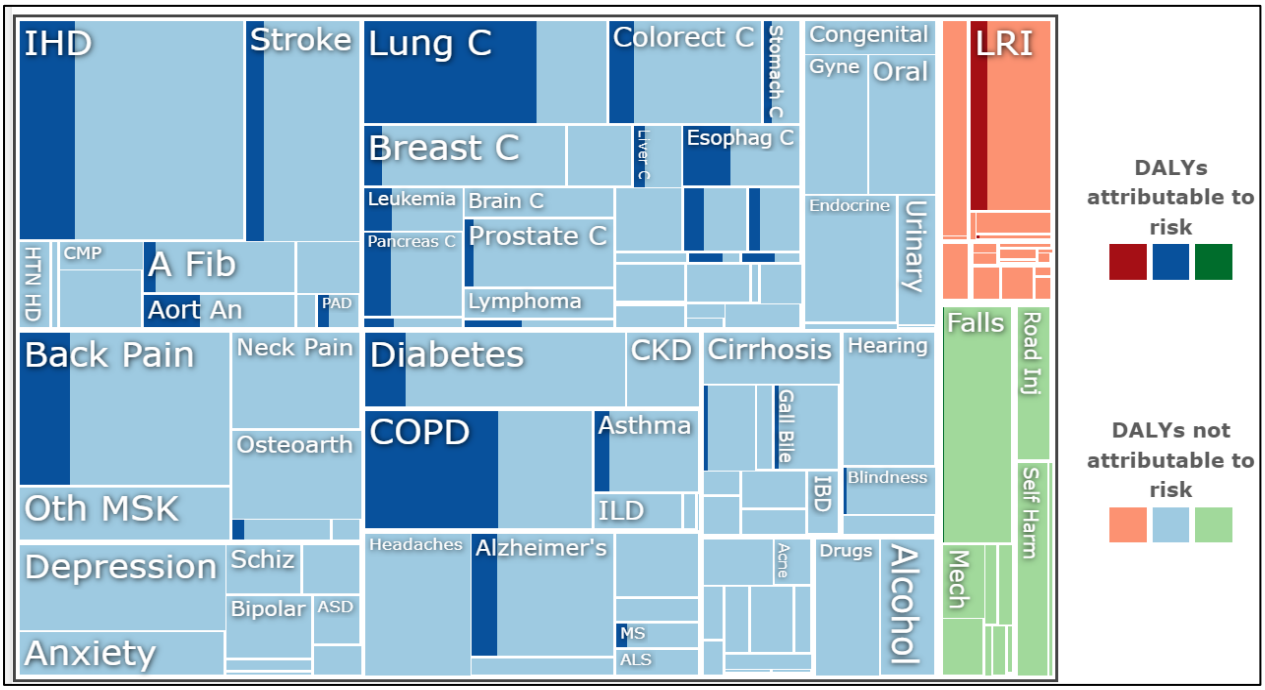
Results show that, in Suffolk 2019, tobacco was attributable to 71.9% of tracheal, bronchus and lung cancers, accounting for 3.8% of total DALYs. Tobacco was also attributable to an array of different cancers including Larynx (68.6%), oesophageal (40.9%), lip or oral cavity (39.6%), bladder (32.1%), leukemia (29.5%), pancreas (28.4%), liver (22.1%), kidney (22.1%), stomach (21.0%), colorectal (16.8%), and prostate (6.3%).

Ischemic heart disease (IHD) had the largest contribution to DALYS in Suffolk 2019, accounting for 7.4% of total DALYS, tobacco was attributable to around a quarter (24.9%) of cases. Tobacco was also attributable to an array of cardiovascular diseases including Aortic aneurysm (37.8%), Peripheral artery disease (28.6%), Stroke (16.1%), and Atrial fibrillation and flutter (8.1%).

Tobacco is also known to contribute to chronic respiratory disease. This is shown in Suffolk, 2019, with over half of all chronic obstructive pulmonary disease (COPD) cases (59.2%) attributable to tobacco and of cases, accounting for 4.2% of total DALYS, and 15.6% of Asthma cases attributable to tobacco- 1.3% of total DALYS.

In Suffolk, 2019, tobacco was also attributable to back pain (24.1%), Alzheimer's (18.8%), Diabetes (15.8%), Multiple sclerosis (14.51%), and Rheumatoid Arthritis (12.7%).

Figure 7: Disability-adjusted life years attributable to tobacco in Suffolk, both biological sexes, all ages, 2019



The colour indicates the broad cause groups:

- Blue: Non-communicable diseases
- Red: Communicable, maternal, neonatal, and nutritional diseases
- Green: Injuries

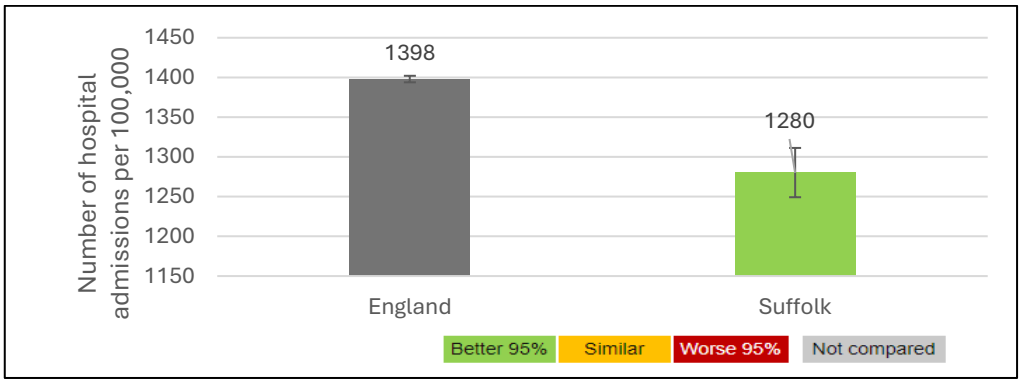
Source: GBD Compare (IHME)

Hospital admissions

Hospital Episode Statistics (HES) is a curated data product containing details about admissions, outpatient appointments and historical accident and emergency attendances at NHS hospitals in England[44]. Figure 8 shows the total number of hospital admissions for diseases that are wholly or partially attributed to smoking in persons aged 35 and over, sourced via the admissions data from Hospital Episode Statistics (HES) for Suffolk, compared to England, for 2019/20. This indicator aims to highlight the size of preventable smoking-related conditions on inpatient hospital services.

High smoking attributable admission rates are indicative of poor population health and high smoking prevalence. Results show that, Suffolk has a statistically significantly better (lower) rate of hospital admissions for diseases that are wholly or partially attributed to smoking in persons aged 35 and over, with 1,280 hospital admissions per 100,000 recorded compared to England's estimate if 1,398 per 100,000.

Figure 8: Total number of hospital admissions for diseases that are wholly or partially attributed to smoking in persons aged 35 and over, 2019/20.



Source: Fingertips

Smoking also increases a person's chances of needing social care. Current smokers are 2.5 times more likely to require social care support at home and need care on average 10 years earlier than non-smokers[45]. In Suffolk smoking-related ill-health means social care is being provided informally by friends and family for 18,400 people. Additionally, smoking-related ill-health causes unmet care needs for a further 7,700 people in Suffolk[40,45].

Concurrent conditions

People who smoke are more likely to live with a long-term health condition (LTC). Both people who smoke and those with an LTC are more likely to be hospitalised and experience worse treatment outcomes[46]. Many LTCs are caused or exacerbated by smoking, meaning stopping smoking is key to reducing complications and improving outcomes[47].

Table 4 presents concurrent conditions of people aged over 15 years old recorded as having a history of smoking (within the past year), for SNEE ICB and Suffolk alliances. A concurrent condition refers to the simultaneous presence of two or more conditions in a patient- in this case a history of smoking (in the past year) and a medical condition.

Results show that around a quarter of individuals in both SNEE ICB (24.7%) and Suffolk alliances (24.4%) with a history of smoking (within the past year) have hypertension. In SNEE ICB around 1 in 10 people with a history of smoking (in the past year) also have chronic respiratory disease (10.6%) or COPD (10.1%). The prevalence is slightly lower in Suffolk alliances with 9.8% of those with a history of smoking (in the last year) reported to have a chronic respiratory disease and 9.3% reported to have COPD.

In addition, in both SNEE ICB (45.7%) and Suffolk alliances (45.9%) around half of people recorded to have a history of smoking (within the past year) also have a mental health flag. A mental health flag is coded when someone has a mental health condition (anxiety, depression, poor mental health, serious mental illness, suicide attempts etc.) in their medical records. Just under a third of people with a history of smoking (within the past year) in both SNEE ICB (31.8%) and Suffolk alliances (31.8%) have depression, and over 1 in 4 people in both SNEE ICB (29.2%) and Suffolk alliances (29.1%) with a history of smoking (within the past year) have anxiety or phobias.

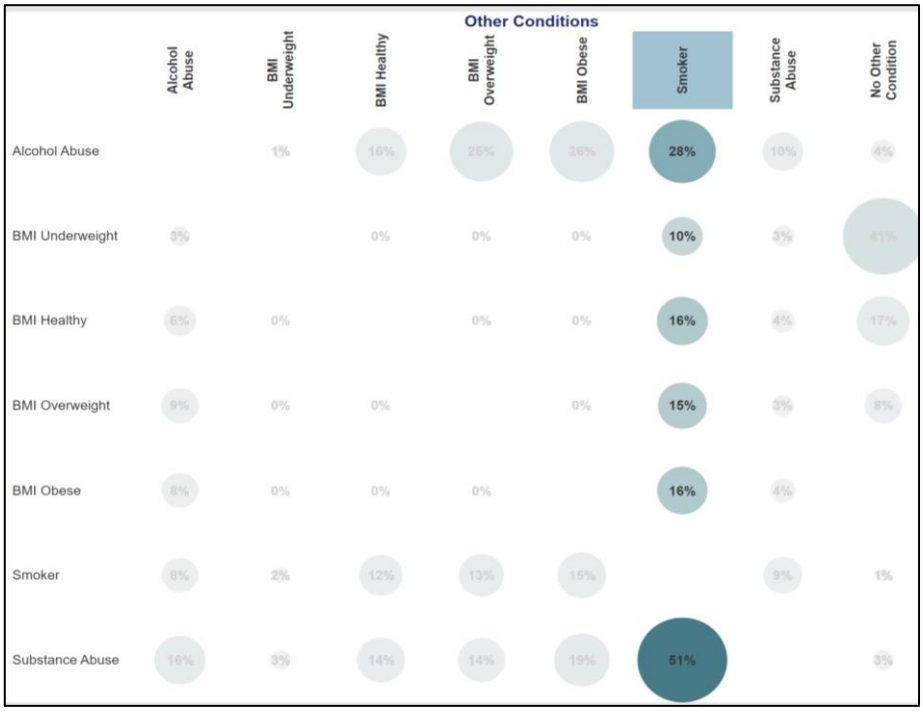
Table 4: Concurrent conditions of people aged over 15 recorded as having a history of smoking (within the past year), shown for the SNEE ICB and Suffolk alliances; December 2022 – November 2023

Patients with a history of smoking in the past year and a recorded diagnosis of:	SNEE ICB	Suffolk alliances
Physical health conditions		
Chronic respiratory disease	10.6%	9.8%
Cancer	6.8%	6.7%
Hypertension	24.7%	24.4%
COPD	10.1%	9.3%
Heart disease	6.2%	6.0%
Mental health conditions		
Serious mental illness	4.2%	3.8%
Mental health flag	45.7%	45.9%
Depression	31.8%	31.8%
Anxiety or phobias	29.2%	29.1%
Social care and support		
Learning disability support	0.3%	0.3%
Social isolation support	0.1%	0.1%
Mental health support	0.3%	0.5%
Short term support	0.6%	0.7%
Long term support	1.6%	1.5%

Source: PHM Dashboard Descriptive Analysis

Figure 9 presents a bubble matrix showing the percentage of people who are also affected by selected health behaviour indicators with a history of smoking in the last year for December 2022 – November 2023 in NHS SNEE ICB. Results show that over half of people with substance abuse recorded have a history of smoking (51%). Additionally, over 1 in 4 people with alcohol abuse have a history of smoking (28%). Just under 1 in 6 people who are overweight or obese (15 and 16%, respectively) have a history of smoking.

Figure 9: Bubble matrix: The percentage of people with specific health behaviours who have a history of smoking in the last year; for SNEE ICB, December 2022 – November 2023



Source: PHM Dashboard Descriptive Analysis

Smoking cost

The ASH ready reckoner is a cost calculator presents the costs of smoking to society in local authorities, combined authorities, regions, and England. Also find estimates for wards and constituencies. Costs are in the categories of productivity, social care, healthcare, and fire.

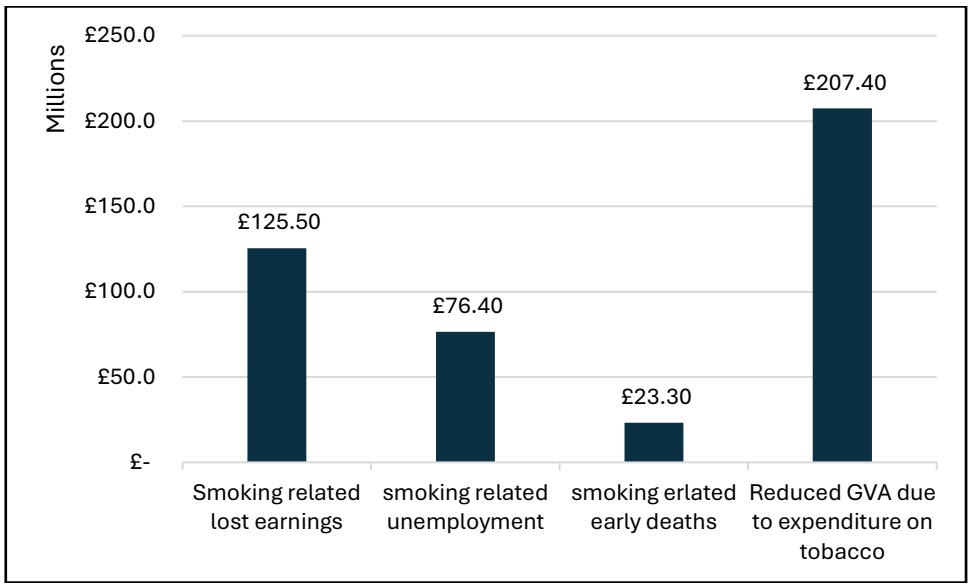
An estimated £266.7 million is spent on tobacco annually across Suffolk- including legal and illicit purchases. The national average annual spend on tobacco is £3,096 per smoker.

In Autumn 20203, the cost calculator found that annual revenue from cigarette and hand-rolled tobacco taxation brings in around £171.9 million for Suffolk. However, each year smoking costs Suffolk £747.2 million, highlighting a £575.3 million cost to Suffolk after accounting for revenue generated. Breaking this figure down, this equates to a £436.6million productivity loss, a £274.4 million social care cost, £32 million healthcare cost because of smoking-related hospital admissions and the cost of treating smoking-related illness via primary care services, and £4.1 million cost related to fires.

Productivity cost

Smoking negatively affects earnings and employment prospects. Figure 10 presents a breakdown of the impact of smoking on productivity for Autumn 2023. Results show that £207.4 million is lost due to reduced gross value added (GVA) due to expenditure on tobacco. £125.5 million is missed due to smoking-related lost earnings. £76.4 million is lost due to smoking-related unemployment, and £27.3 million is lost to smoking-related early deaths.

Figure 10: Cost of smoking on productivity in Suffolk, Autumn 2023

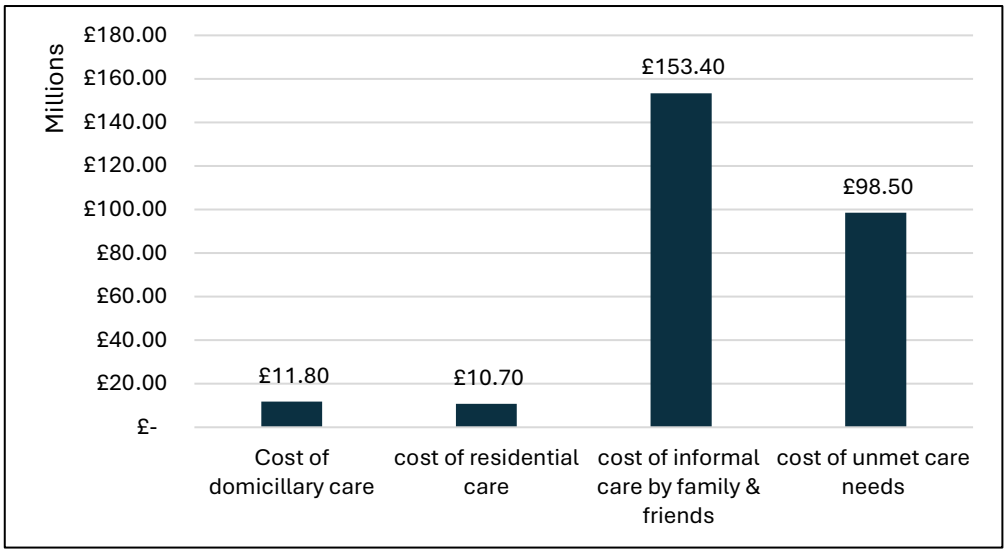


Source: ASH Ready Reckoner

Social care cost

Many current and former smokers require care in later life because of smoking-related illness. The estimated social care cost due to smoking for Suffolk as of Autumn 2023 is £274.4 million. Figure 11 provides a breakdown of the social care costs due to smoking. Results show that informal care by family and friends costs £153.4 million, unmet care needs costs £98.5 million, domiciliary care costs £11.8 million and residential care costs £10.7 million.

Figure 11: Social care costs due to smoking in Suffolk, Autumn 2023



Source: ASH Ready Reckoner

Healthcare cost

QALYs (Quality-Adjusted Life Years) are a measure that combines both the quantity and quality of life for a person or group. It calculates the equivalent number of years in perfect health based on life expectancy and quality of life factors like ability to perform daily activities, freedom from pain/distress, and overall wellbeing[48]. The QALY value of life lost due to smoking was estimated at £439.7 million for Suffolk, in autumn 2023. This accounts for the Green book QALY value (guidance issued by HM Treasury outlining methodology for estimating the monetary valuations of QALYs for the UK) applied to the intrinsic value of life lost due to premature deaths from smoking.

Table 5 shows the finance per person per year (PPPYs) for people aged 15 and over recorded as having a history of smoking (within the past year) for SNEE ICB and Suffolk alliances. Results show that people with a history of smoking (within the past year) higher costs per year compared to the population average. The highest cost for those recorded as having a history of smoking for both SNEE ICB and Suffolk alliances came from acute unplanned care. This is different to the population average where the highest cost came from general practice.

Table 5: Finance PPPYs for people aged 15 and over recorded as having a history of smoking (within the past year), ICB and Suffolk alliances level; December 2022 – November 2023

	SNEE ICB		Suffolk alliances	
	History of smoking (within the past year)	Population average	History of smoking (within the past year)	Population average
Total PPPY	**£2,222**	**£1,538**	**£2,230**	**£1,484**
Acute Planned	£469	£325	£479	£330
Acute Unplanned	£566	£303	£564	£301
Acute Drugs & Devices	£33	£28	£29	£23
General Practice	£550	£390	£545	£398
Community & Mental Health	£254	£143	£257	£141
Adult Social Care	£351	£349	£355	£292

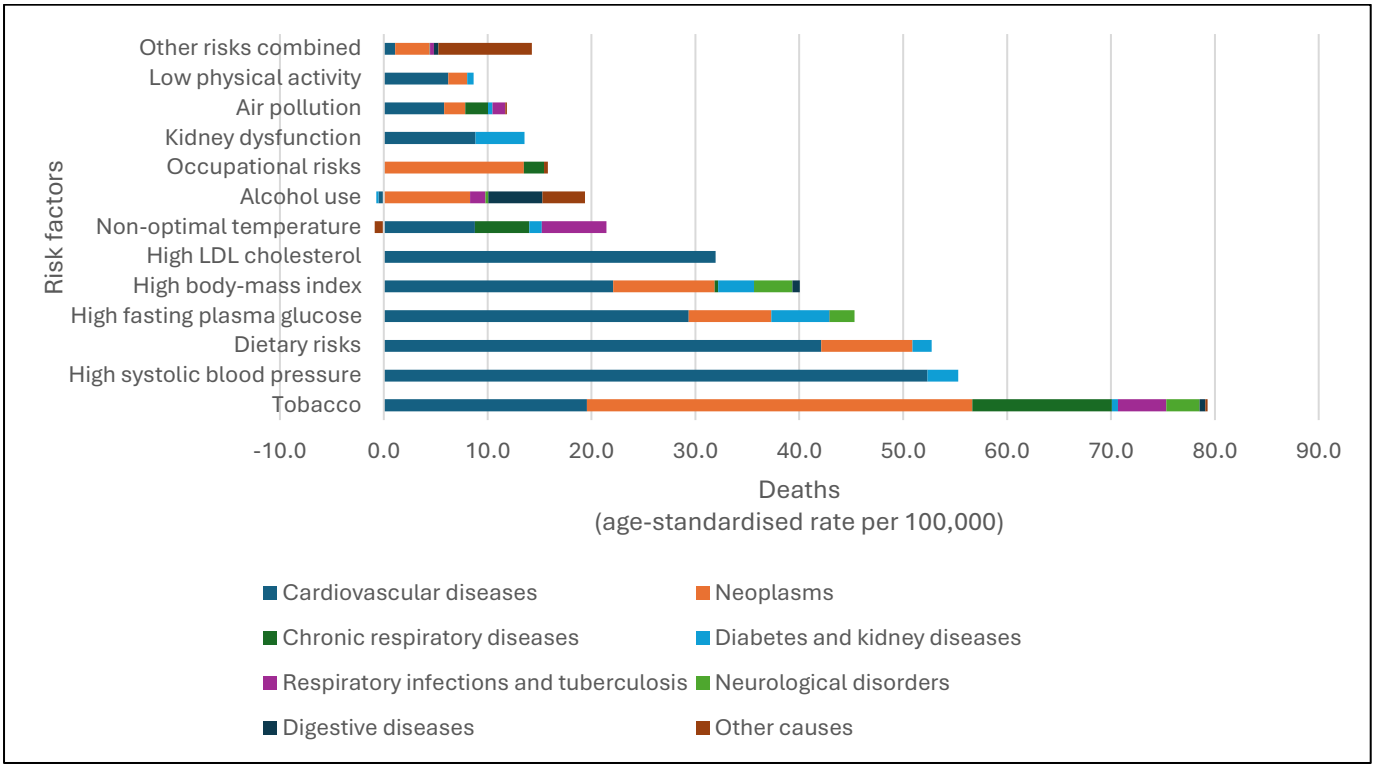
Source: PHM Dashboard Descriptive Analysis

Smoking related mortality

It has been estimated that around 970 people in Suffolk die each year due to smoking and 4,400 potential years of life are lost each year in Suffolk due to smoking[49].

Figure 12 shows the attribution of risk factors to causes of death in Suffolk for 2019 as reported in the Global Burden of Disease Study . Results show that tobacco presents the single greatest risk for early deaths in Suffolk. This means that using smoked tobacco products poses a greater risk than other issues such as high blood pressure, obesity, alcohol, and air pollution.

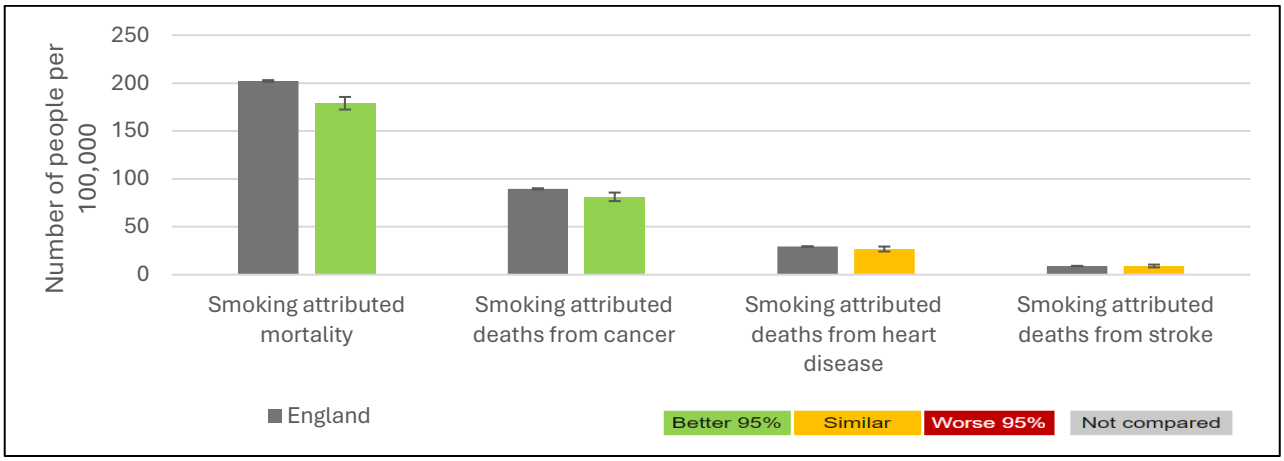
Figure 12: Attribution of risk factors to causes of death in Suffolk, 2019



Source: Institute for health metrics and evaluation.

Smoked tobacco products contribute to early deaths from non-communicable diseases[1]. Figure 13 shows the smoking attributable deaths for overall mortality and from cancer, heart disease and stroke for Suffolk, compared to England for 2017-2019. Results show that, in Suffolk, smoking attributable mortality was statistically significantly lower than the England estimate of 202.1 per 100,000, with an estimate of 178.9 per 100,000. Smoking attributable deaths from cancer are also statistically significantly lower than the England estimate of 89.6 per 100,000 with a rate of 81.2 per 100,000. Smoking attributed deaths from heart disease in England is estimated at 29.3 per 100,000, Suffolk has a statistically similar rate of 26.7 per 100,000. Finally, Suffolk has the same rate of smoking attributed deaths from stroke to England with a rate of 9.0 per 100,000.

Figure 13: Smoking attributable deaths for overall mortality and from cancer, heart disease and stroke for Suffolk, compared to England, 2017-2019



Source: Fingertips

Smoking trading standards

Suffolk Trading Standards help to stop the sale of illicit tobacco products. In 2022-23 Suffolk Trading Standards seized 15,263 cigarette sticks and 7.3kg of hand rolling tobacco. So far, in 2023-24, 23173 cigarette sticks and 16kg of rolling tobacco have been seized.

Incidents related to smoking

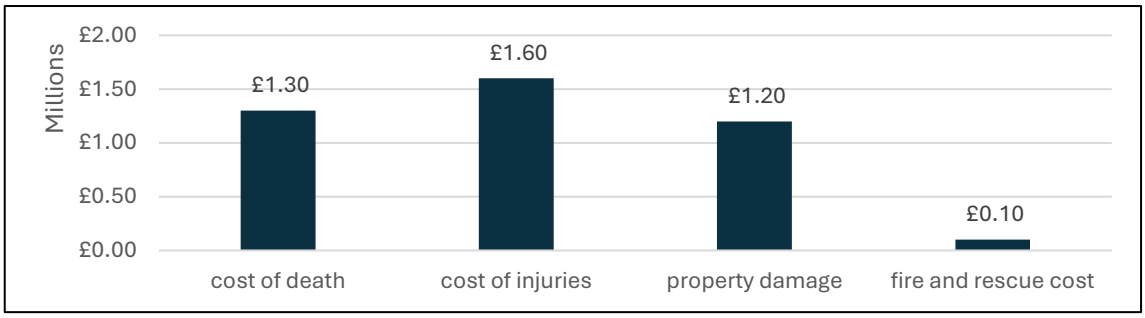
Smoking materials are a major contributor to accidental fires. Table 6 presents the total number of fire incidents involving cigarettes, from 2017 to 2023. Results show that the number of incidents involving cigarettes has decreased year on year (with the exception of 2021) from 54 in 2017 to 34 in 2023. However, due to the total number of fires in a year largely decreasing by 1,017 from 2022 to 2023, the proportion of incidents involving cigarettes has increased to 3.23% in 2023. This suggests that more focus is needed to highlight the dangers of smoking materials to help reduce these incidents further in future.

Table 6: Incidents involving cigarettes in Suffolk from 2017 to 2023

Year	Incidents	Total fires in year	Percentage (%)
2017	54	1695	3.19
2018	52	2014	2.58
2019	41	1690	2.43
2020	43	1779	2.42
2021	45	1491	3.02
2022	42	2069	2.03
2023	34	1052	3.23

Smoking related fires result in annual losses of £4.1 million. Figure 14 provides a breakdown of fire costs due to smoking across Suffolk for Autumn 2023. Results show that injuries from incidents involving cigarettes cost £1.6 million, deaths from incidents cost £1.3 million, property damage costs £1.2 million and the fire and rescue support costs £100,000.

Figure 14: Fire costs due to smoking (in millions), across Suffolk, Autumn 2023



Source: ASH Ready Reckoner

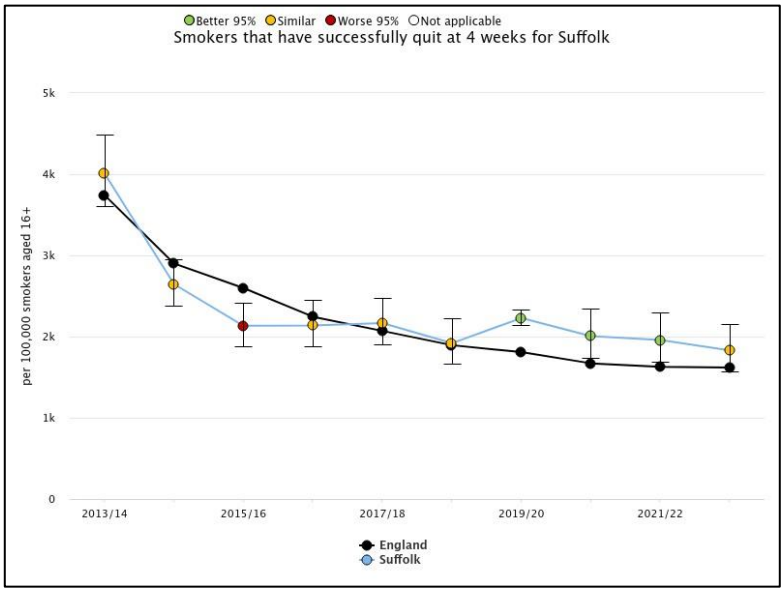
Smoking quitters

NHS Stop Smoking Services offer support to help people quit smoking. This can include intensive support through group therapy or one-to-one support. The support is designed to be widely accessible within the local community and is provided by trained personnel, such as specialist smoking cessation advisers and trained nurses and pharmacists[50].

Data regarding smokers that have successfully quit at 4 weeks is collected on NHS Stop Smoking returns in line with requirements from the Department of Health (DH). Successful quitters are those smokers who successfully quit at the four-week follow-up. A client is counted as a 'self-reported 4-week quitter' when assessed four weeks after the designated quit date, if they declare that they have not smoked, even a single puff on a cigarette, in the past two weeks.

Figure 15 shows the number of smokers that have successfully quit at four weeks in Suffolk between 2013/14 and 2022/23 compared to England. Results show that, in 2022/23, there were 1,830 successful quitters per 100,000 smokers aged 16 and over at four weeks in Suffolk, similar to the England estimate of 1,620 per 100,000 smokers aged 16 and over. This is also a decrease of 128 people per 100,000 when compared to successful quitters in Suffolk at four weeks in 2021/22.

Figure 15: Smokers that have successfully quit at 4 weeks in Suffolk, between 2013/14 and 2022/23, compared to England.

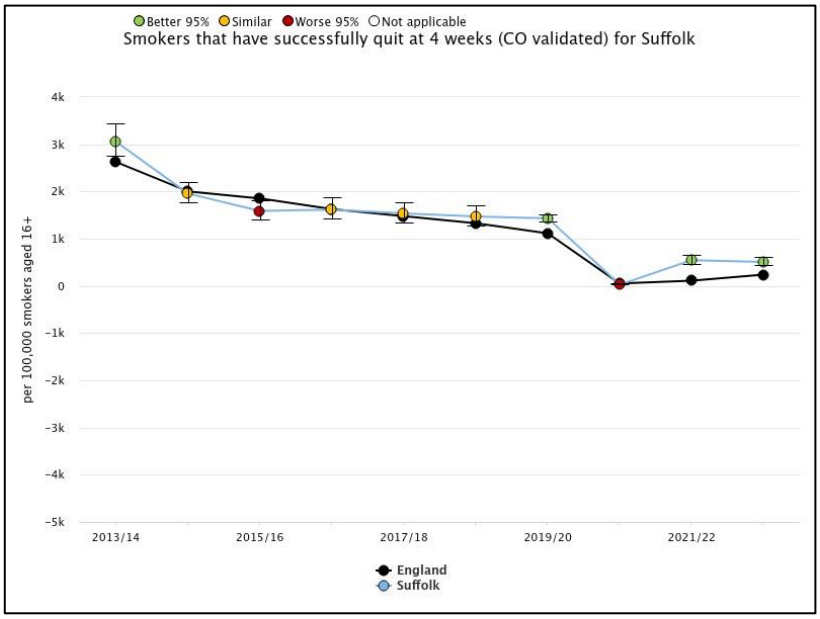


Source: Fingertips

Figure 16 shows the number of smokers that have successfully quit at four weeks that have been carbon monoxide (CO) validated per 100,000 smokers aged 16+ between 2013/14 and 2022/23, compared to

England. CO validation measures the level of carbon monoxide in the bloodstream and provides an indication of the level of use of tobacco. CO validated smoking quits provide an objective measure in addition to self-reported quits, and CO validation may also help incentivising clients to quit. Results show that overall, the number of successful quitters at four weeks that have been CO validated has decreased over time. In Suffolk, 2022/23, 505 people per 100,000 smokers aged 16+ were recorded at successful quitted and CO validated, this is statistically significantly better than the England estimate of 237 per 100,000.

Figure 16: Smokers that have successfully quit at 4 weeks (CO validated) in Suffolk, between 2013/14 and 2022/23, compared to England.



Source: Fingertips

Although the number of successful quitters in Suffolk has decreased, the proportion of smokers is also decreasing; therefore, the decrease in the number of quitters may be due to smokers using alternative means to support their quit efforts.

Vaping/e-cigarettes: data & intelligence

The national picture

Data for vaping and e-cigarette use comes from the Opinions and Lifestyle Survey (OPN), which covers adults aged 16 years and over in Great Britain. This was also reported within the Adult smoking habits in the UK: 2022. Key findings are as follows:

- 5.2% of GB adults in 2022 were daily e-cigarette users, up from 4.9% in 2021.
- Higher daily/occasional vaping rates are higher among men (9.5%) than women (7.9%)
- Vaping and e-cigarette use was found to be most popular among current and ex-smokers. However, there is increasing use among individuals who had never smoked. Around 2.4% of people who have never smoked reported that they were daily or occasional e-cigarette users in 2022, an increase from 1.5% in 2021.
- Changes in e-cigarette usage are particularly evident in younger females, with a statistically significant increase in the proportion of women aged 16 to 24 years who were daily e-cigarette users in 2022 (6.7%), compared with 2021 (1.9%).

The local picture

Prevalence & trends

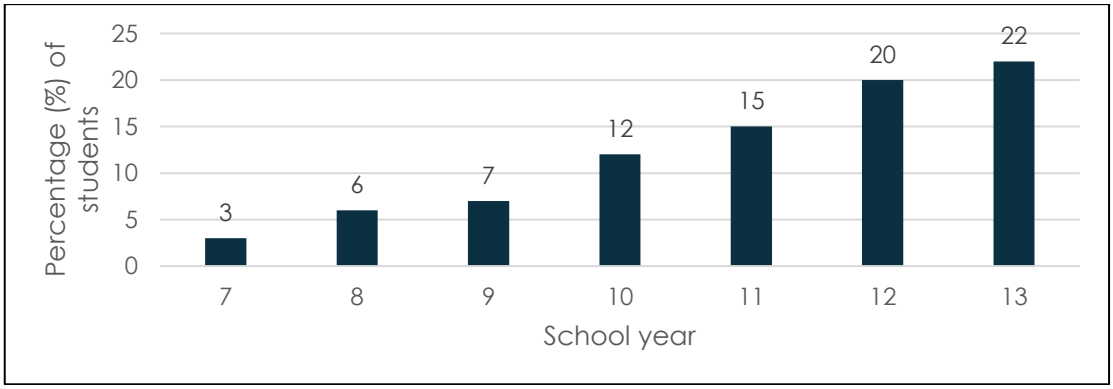
In the UK, it is illegal to sell vapes to people under the age of 18. However, results from the GB adults and youth survey show that the proportion of children experimenting with vaping is growing by 50% each year- shown from a usage of one in 13 in 2022 to one in nine in March/April 2023[51].

The e-cigarette industry is relatively new. This means that there is limited evidence on topics such as the prevalence of vape or e-cigarette use at local level. However, in 2023, Healthwatch Suffolk published My Health, Our Future (MHoF) Phase 7[52]. MHoF is a unique research programme exploring the physical and mental wellbeing of children and young people in Suffolk. This report presents findings from a survey completed by more than 13,000 children and young people in secondary schools and colleges across Suffolk between December 2022 and July 2023. The MHoF survey asked Suffolk students whether they currently vaped. Results show that:

- 12% (1,272 people) had vaped- with 11% of participants vaping at the time of the survey
- 5% (531 people) vaped but never smoked
- 4% (469 people) vaped and smoked
- 2% (272 people) vaped and used to smoke

Older students were more likely to vape than younger students. Figure 17 shows the proportion of students who reported they vaped by school year. Results show that prevalence increased as students progressed through school with the largest proportion of students vaping in Year 13 (22%) followed by Year 12 (20%) and year 11 (15%).

Figure 17: Percentage of students who reported they vaped in MHoF Phase 7 survey, Suffolk, 2023



Source: Healthwatch Suffolk

Certain students were more likely to vape than their peers. Students who reported at least one additional support need were more likely to vape than their peers (16% vs. 8%). Female students were more likely to vape than male students (12% vs. 8%). Those who preferred to describe their gender another way were the most likely to vape (17%). White- Gypsy Traveller or Irish Traveller (29%) and Arab (21%) students were more likely to vape compared to other ethnic groups.

1,272 students answered the question 'why do you vape'- shown in table 7. Results show that over 1 in 3 (39% [496 people]) said they liked the feeling It gives them. This was closely followed by liking the smell/flavour (31% [393 people]) and being addicted to them (31% [395 people]).

Table 7: MHoF Phase 7 results for question 'why do you vape', Suffolk, 2023

Statement	%	Count
To give it a try	18%	228
To quit smoking tobacco	12%	148
Addicted to them	31%	395
Like the feeling it gives me	39%	496
Like the smell or flavour	31%	393
My friends do it	23%	295
Easier to get than cigarettes	11%	134
I don't know	19%	236

Source: Healthwatch Suffolk

Students' reasons for vaping varied by whether they currently vape and smoke, had previously smoked or had never smoked. Students who had never smoked were less likely to say that they were addicted to vaping. They were more likely to say that they vaped 'to give it a try.' Nearly a quarter of those who said that they currently vape and used to smoke said that they were trying to quit smoking tobacco. Of those who currently smoke and vape 17% were trying to quit tobacco.

Suffolk vaping/e-cigarette demographic

Local data related to vaping prevalence was collected at ICB and alliances level in Axym. Axym brings together a range of data sets which allow the data to be analysed for a range of purposes. It also allows users from different organisations to access data environments in a safe way so that they can use and interrogate the data. Vaping - 35 SNOMED codes and One ICD-10 code were used to define history of vaping, including people who have ever vaped (ex-vapers) and those currently vape from April 2008 to March 2024. Timebound indicators (such as living in Rural/Urban) are from March 2024.

Patient's locations were defined as the most recent home address. Data was filtered by relevant LSOA names (i.e., Ipswich, Colchester, Tendering, West Suffolk, etc.), to ensure that the data was only extracted for patient's living in relevant area (SNEE or Suffolk Alliances) and registered with the GP in the relevant area (SNEE or Suffolk Alliances).

Data is not included on patients that fit in the following criteria:

- Not registered with a SNEE GP
- Deceased
- Opted Out of sharing Health Records

Table 8 shows the count and percentage of people who have been recorded as vapers for NHS SNEE ICB and combined Ipswich and East Suffolk and West Suffolk alliances level from April 2008 to March 2024. Results show that 17,014 people (1.7% of the population) in SNEE and 10,820 (1.7% of the population) in the Suffolk alliances are recorded as vapers. For both SNEE and Suffolk alliances a lower proportion of vapers are male, and an average of 7.8% in SNEE and 7.9% in the Suffolk alliances are from ethnic minority groups (compared with 10.5% and 9.9% of the population, respectively).

Table 8: Percentage of patients registered to GP within SNEE/Suffolk Alliances boundary and who live within the respective boundary that have ever vaped; April 2008-March 2024

	SNEE ICB		Suffolk alliances	
	Count	%	Count	%
Vaping prevalence	17014	1.7	10820	1.7
Proportion of vapers that are Male	8238	48.4	5327	49.2
Proportion of vapers that are from an ethnic minority group (if recorded)	1324	7.8	905	8.4

Source: Axym

Table 9 provides the count and percentage of SNEE and Suffolk Alliances residents registered to a GP within SNEE and Suffolk alliances that have a history of vaping between April 2008 and March 2024 split by age.

Results show that the highest proportion of people with a history of vaping was in the 50–59-year-old population for both SNEE ICB (2.7%) and Suffolk alliances (2.7%). This was closely followed by 40–49-year-olds for both SNEE ICB (2.6%) and Suffolk alliances (2.5%), and 60-69 year olds for SNEE ICB (2.3%) and 30-39 year olds for Suffolk alliances (2.3%).

The age group with the lowest proportion of individuals recorded as having a history of vaping was 10-19 years old for both SNEE ICB (0.4%) and Suffolk alliances (0.3%).

Table 9: Percentage of patients registered to GP within SNEE/Suffolk alliances boundary and who live within the respective boundary that have ever vaped by age group; April 2008-March 2024

	SNEE ICB		Suffolk alliances	
	Count	%	Count	%
10-19 years old	395	0.4	242	0.3
20-29 years old	2124	2.0	1447	2.3
30-39 years old	2850	2.2	1890	2.3
40-49 years old	3158	2.6	1968	2.5
50-59 years old	3610	2.7	2315	2.7
60-69 years old	2799	2.3	1754	2.2
70-79 years old	1645	1.5	958	1.4
80 years and over	430	0.5	243	0.4

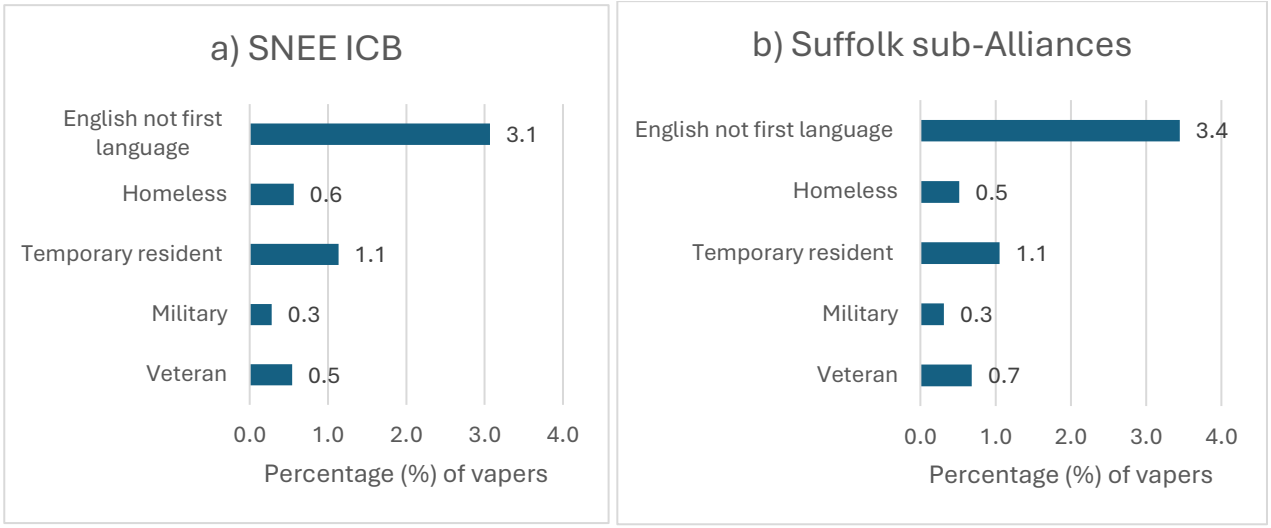
Source: Axym

Figure 18 shows the percentage of people within selected demographics with a history of vaping (where recorded) for both SNEE ICB and Suffolk alliances. The data indicates that English is not the first language for 3.1% of vapers in SNEE ICB and 3.4% of vapers in Suffolk alliances.

0.8% of people who have been recorded to vape in SNEE ICB between April 2008-March 2024 are either in the military or are a veteran, compared to 1% of vapers for Suffolk alliances.

Additionally, 1.1% of vapers in both SNEE ICB and Suffolk alliances are recorded as temporary residents, and 0.6% of vapers in SNEE ICB are homeless compared to 0.5% in Suffolk alliances.

Figure 18: Demographic groups of people who have been recorded as vapers in a) Suffolk and North East Essex ICB and b) Ipswich and East Suffolk and West Suffolk alliances; April 2008- March 2024



Source: Axym

Table 10 presents the number and percentage of vapers living in urban and rural areas for March 2024. Results show that for both SNEE ICB and Suffolk alliances around 2 in 3 vapers live in urban areas.

Table 10: The percentage of vapers living in urban or rural areas; March 2024

	Rural		Urban	
	Count	%	Count	%
SNEE ICB	5700	33.5	11,314	66.5
Suffolk alliances	3949	36.5	6871	63.5

Source: Axym

Vaping/e-cigarette & ill-health

Concurrent conditions

Table 11 presents concurrent conditions of people recorded as vaping, shown for the SNEE ICB and Suffolk alliances; April 2008-March 2024. Results show that over one in five of individuals in both SNEE ICB (21.0%) and Suffolk alliances (21.1%) with a history of vaping have suffered from hypertension between April 2008-March 2024. In SNEE ICB around 1 in 10 people with a history of vaping have also suffered from Chronic respiratory disease (10.4%) or COPD (9.9%) between April 2008 and March 2024. The prevalence is slightly lower in Suffolk alliances with 9.6% of those with a history of vaping reported to have chronic respiratory disease and 9.2% reported to have COPD between April 2008 and March 2024.

In addition, around a third of people with a history of vaping in both SNEE ICB (33.1%) and Suffolk alliances (33.5%) have been reported to suffer from anxiety between April 2008 and March 2024. Just under a third of people with a history of vaping in both SNEE ICB (30.8%) and Suffolk alliances (30.9%) have also been reported to suffer from depression between April 2008 and March 2024.

However, it is important to note that, for this analysis, the smoking history for people with a history of vaping is unknown and may impact findings.

Table 11: Concurrent conditions of people recorded as vaping, shown for the SNEE ICB and Suffolk alliances; April 2008-March 2024

	SNEE ICB		Suffolk alliances	
Physical health conditions				
	%	Count	%	Count
Chronic respiratory disease	10.4	1766	9.6	1033
Cancer	4.7	804	4.6	493
Hypertension	21.0	3575	21.1	2286
COPD	9.9	1689	9.2	990
Heart disease	5.5	941	5.5	590
Mental health conditions				
	%	Count	%	Count
Serious mental illness	4.0	681	3.6	391
Depression	30.8	5242	30.9	3348
Anxiety	33.1	5628	33.5	3623
Social care and support				
	%	Count	%	Count
Learning disability support	0.2	38	0.3	37
Mental health support	0.2	32	0.3	32
Physical Health support	0.4	73	0.7	73

Source: Axym

Vaping/e-cigarette trading standards

Suffolk Trading Standards help to stop the sale of illicit vape products. Currently, the Suffolk Trading Standards have seized more than double the number of illicit vapes seized in the previous year (currently 5930 vapes 2023-24, compared to 2821 in 2022-23). These items did not comply with the Tobacco and Related Product Regulations 2016 and contained incorrect health warnings or images. The packaging of some of the vaping liquids sold also made the product resemble food, with this mirroring popular sweet branding – enticing impressionable young people into buying the liquids.

Suffolk Trading Standards have also found an increasing correlation between vape sellers and illicit tobacco sellers (if selling either illicit vape or tobacco becoming increasingly likely to sell the other as well). Underage sales intelligence is often linked to these problem premises, with approximately 64% of the underage sales intelligence received in relation to vape sales- this is increasing.

In Suffolk, non-compliant vapes were initially displayed around the till area, trader awareness now means these too are largely being concealed. Methods of selling illicit products have also moved from under the counter to vehicles/ private dwellings and expensive elaborate concealments.

Consumers can protect themselves by only buying e-cigarettes and vaping liquids from reputable retailers. These should be sold in proper packaging – liquids must be in childproof bottles displaying nicotine warnings – and come with an accompanying safety leaflet. If this is not the case, it may mean that the products do not comply with regulations and could be dangerous, so should be disposed of as a precaution.

Incidents related to vaping/e-cigarette

4 fires in total between 2017 and 2023 involved vaping materials. Incidents involving vapes have been historically harder to capture in the data due to coding. However, in 2024 a separate category to record vape incidents within a new iteration of the data system will be introduced.

Local target areas and population groups

Local areas can identify priority populations and provide them with enhanced support to quit. Therefore, this section identifies local target areas and population groups in Suffolk where smoking is more prevalent to support in accelerating local smoking cessation.

Smoking

Children & young people

The younger an individual starts to smoke, the more harm is likely to be caused, with early smoking associated with heavier smoking, increased dependency, a lower chance of quitting and higher mortality. Childhood smoking can also cause serious risks to respiratory health, impairing lung growth and initiating premature lung function decline[53–55].

It is estimated that each year around 207,000 children in the UK start smoking[56]. Among adult smokers, almost 40% had started smoking regularly (defined as at least one cigarette per week) before the age of 16[57]. About two-thirds report that they took up smoking before the age of 18[58], and 4 in 5 smokers (over 80%) are reported to start before the age of 20[47].

Risk factors of smoking initiation

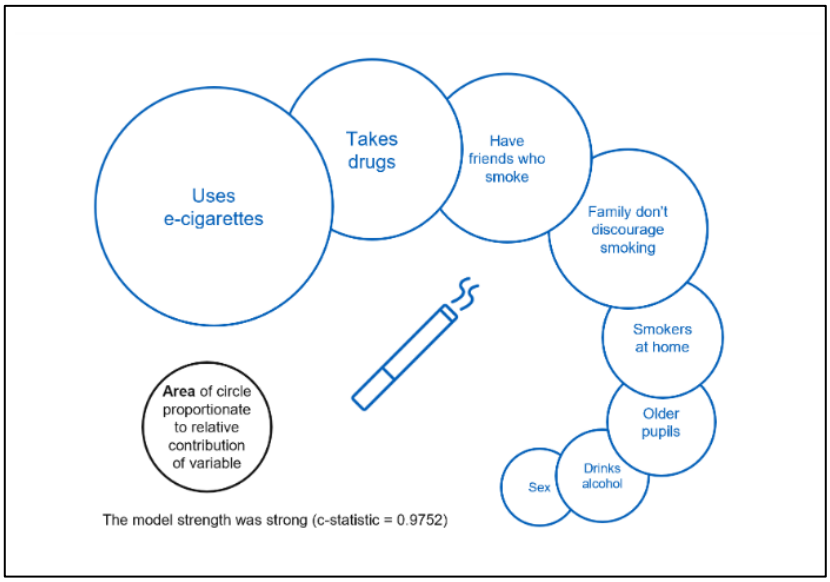
Smoking initiation is associated with a wide range of risk factors including: parental and sibling smoking, the ease of obtaining cigarettes, smoking by friends and peer group members, socio-economic status, exposure to tobacco marketing, and depictions of smoking in films, television and other media[53].

Figure 19 presents findings from a linear regression model used to explore which characteristics might be associated with current smoking. This identifies factors which identify pupils with an increased or decreased likelihood of being smokers. Eight factors were found to have a significant association with current smoking.

These included:

- using e-cigarettes
- takes drugs
- have friends who smoke
- family doesn't discourage smoking
- smokers at home
- older pupils
- drinks alcohol
- biological sex

Figure 19: Infographic highlighting findings from a linear regression model used to explore which characteristics might be associated with current smoking



Source: NHS Digital

Having a friend or family member that smokes increases a child's risk of starting to smoke. In 2021, the DHSC reported that children whose parents smoke are 4 times as likely to take up smoking themselves[59]. Similar patterns were also shown in the secondary school pupils survey, with almost all current smokers having a friend who smoked, compared to around a third of non-smokers. Current smokers were also more likely to have a family member who smoked (72%) compared to non-smokers (58%). Only 3% of current smokers reported not knowing anyone who smoked, compared with 30% of non-smokers[60].

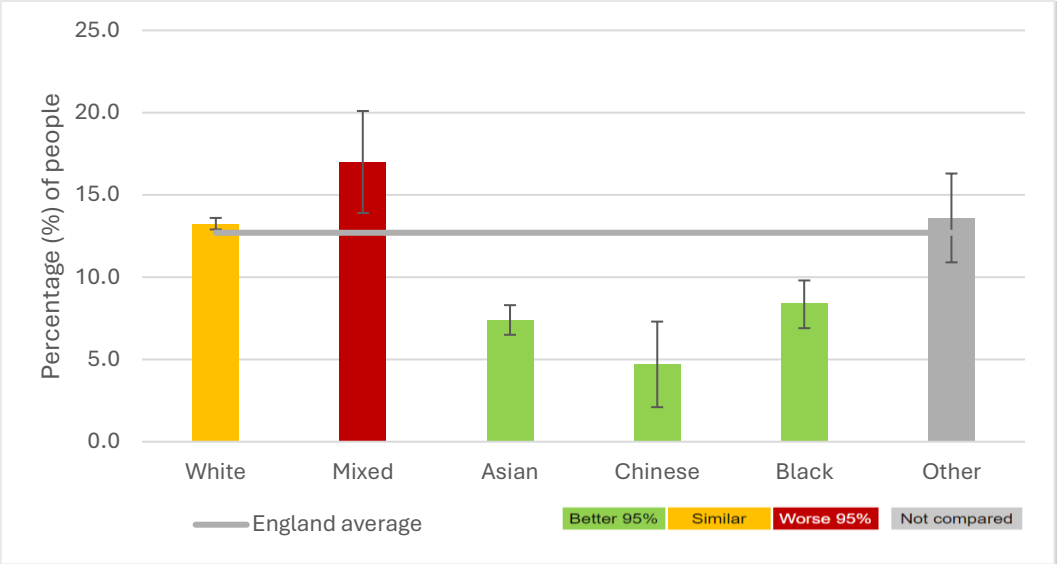
Children who live with parents or siblings who smoke are also up to three times more likely to become smokers themselves than children of non-smoking households[59]. It is estimated that, each year, at least 23,000 young people in England and Wales start smoking by the age of 15 as a result of exposure to smoking in the home[53].

Second-hand smoke (SHS) has also been suggested to be an independent factor for susceptibility to smoking. Prospective studies have described SHS exposure at home as a more substantial risk factor than parental smoking, and it has also been reported to hinder smoking cessation[61]. In 2021, a little over half (52%) of pupils reported being exposed to SHS in a home, including both at home or at someone else's home, or in a car. This is down from 60% in 2018[60]. 11% of pupils were exposed every day or most days[60].

Ethnicity

Figure 20 presents the smoking prevalence across different ethnic groups for England. Due to the small sample size surveyed the "other" category refers to an aggregation of the remaining 13 ethnic groups surveyed[62]. Nationally, the data indicates elevated rates among the white and mixed ethnic populations. Approximately 17% of individuals from mixed ethnic backgrounds and 13.2% of the white ethnic group are classified as current smokers. These percentages are statistically higher compared to other minority groups, such as the black ethnic group with an 8.4% smoking prevalence and the Chinese ethnic group at 4.7%.

Figure 20: Smoking prevalence in adults aged 18 and over by Ethnicity for England, 2022



Source: Office for Health Improvement and Disparities

Immigration patterns also have implications for tobacco use and control efforts in the UK. Individuals migrating to the UK may originate from countries with different legal frameworks and cultural norms surrounding tobacco compared to existing policies and attitudes in the UK.

When people immigrate to the UK, many come from countries with higher smoking rates. The World Health Organisation estimates that in 2020, 24% of the Polish population aged 15 and older were current smokers. Similarly elevated rates were observed in Bulgaria (39%), Portugal (25.4%), and Romania (28%). Notable gender disparities also exist, with 30.5% of Portuguese males smoking versus 20.2% of females[63].

Tobacco causes health problems across all ethnicities, but the way people from different ethnic backgrounds use tobacco varies considerably. Some ethnic minorities are substantially more likely to use smokeless tobacco (in particular, South Asian British) and shisha pipes (in particular, Middle Eastern and South Asian British). However, smoking remains the most common form of tobacco use in all communities[64].

2021 census data shows that Suffolk's population remains less diverse than that of England and Wales overall. The percentage of the Suffolk population that are not White English, Welsh, Scottish, Northern Irish or British has increased from 9.2% in 2011 to 12.7% in 2021 but remains less than half of the England and Wales figure of 25.6%.

Gypsy, Roma, and Traveller community

The majority of records consistently indicate that GRT communities have poorer overall health and wellbeing compared to other ethnic minority groups and to the population as a whole[65]. The 2022 GP survey found a higher proportion of respondents who identified as Gypsy, Roma, or Traveller were most likely to say they were regular smokers. Around 1 in 4 of those who identified as White Roma (24.8) and those who identify as Gypsy or Irish Traveller (24.7%) classified themselves as regular smokers[66].

In Suffolk, White Irish, Gypsy or Irish Traveller and Roma communities account for a similar proportion of the population (0.8%) to across England and Wales (1.1%) as a whole. Suffolk's Gypsy, Roma, and Traveller Community Health Needs Assessment identifies high prevalence of smoking as a key health priority.

Armed forces & Veterans

Tobacco smoking has a major impact on armed forces and veterans' health. Research in the 1950s and 1960s showed that people who were then young soldiers were smoking around 20% more than civilians; 50 years later, up to 10% of veterans have experienced at least one major smoking-related health outcome, reflecting the consequences of this earlier smoking pattern. Changes to military smoking policy were made in 2006 with a ban on indoor smoking, but it will be many years before the health benefits become measurable[67].

Table 12 shows the percentage of UK armed forces personnel defined as a smoker by service and gender between the 1st April 2011 and 1st of April 2020. Results show that tri-Service smoking rates are continuing to fall, and are now down to 19% of men and 12% of women, although the rate for Army personnel is higher at 23% of men and 15% of women[68]. These figures remain higher than the UK national rate.

Table 12: UK armed forces personnel defined as a smoker by service and gender, percentages 1 April 2011 to 1 April 2020

Year	All (%)			Naval Services (%)			Army (%)			RAF (%)		
	All	Male	Female	All	Male	Female	All	Male	Female	All	Male	Female
2011	27	27	23	23	23	23	32	32	25	18	18	19
2012	27	27	21	23	23	21	32	33	24	18	17	18
2013	26	27	20	22	22	20	31	32	23	17	17	17
2014	25	25	19	20	21	18	29	30	21	16	16	15
2015	23	24	18	19	19	17	28	29	20	14	14	14
2016	22	22	16	18	18	16	27	27	18	13	13	13
2017	20	21	15	17	17	14	25	26	17	12	12	11
2018	20	20	14	16	16	13	24	25	16	11	11	10
2019	19	19	13	15	15	12	23	24	15	10	11	9
2020	18	19	12	15	15	11	23	23	15	10	11	8

Source: Ministry of Defence

In response to this, a Tri-Service Tobacco Control Working Group has been introduced to help establish smoking cessation pathways including identifying ways of discouraging recruits from starting smoking, including banning instructors from smoking in front of trainees. This provides an opportunity for utilising learning from local stop smoking services and local collaboration to support increasing the number of cessation attempts in local armed forces populations[69].

Moreover, the Scottish Veterans Health Research Group published an updated report on the trends in Scottish veterans' health in August 2022[67]. The report found that the biggest single influence on veterans' health was tobacco smoking. The report found that over a maximum of 37 years' follow-up, 5.4% of the cohort of Scottish veterans were diagnosed with COPD, a further 1% of the veterans had been diagnosed with lung cancer, 4% of veterans had had a heart attack and 1.3% had been diagnosed with peripheral arterial disease. For all these conditions, smoking is the biggest risk factor. There are many other smoking-related conditions where the risk in veterans exceeds that in non-veterans, such as duodenal ulcer and cancer of the mouth and throat, which were out of scope for this publication.

Even when allowing for some overlap for people with more than one condition, at least one in 20 veterans, and possibly closer to 1 in 10, has experienced a major smoking related disease with life-long (and possibly life-limiting) consequences. This report therefore highlights tobacco smoking as a modifiable threat to veterans' health and stopping smoking at any age, even into older age, reduces the risk[67].

Furthermore, the study illustrated the complexity of the factors influencing veterans' health. Background societal and personal factors interact with both in-service experiences and factors operating in post-service life, and the net impact is modulated by individual lifestyle choices. Length of service is important, with

longer-serving veterans generally enjoying better long-term health than those who leave early, especially those who fail to complete the minimum engagement. Thus, there is both a 'healthy worker effect' and a 'less healthy leaver' effect.

At the time of the 2021 Census there were 30,976 UK armed forces veterans residents in Suffolk. This equates to 4.9% of people aged 16+ resident in the county; two percentage points higher than the England and Wales average. Of these, 24,371 previously served in the UK regular armed forces (3.9% of residents aged 16+), 5,202 previously served in UK reserve armed forces (0.8%) and 1,403 (0.2%) previously served in both of these forces.

With around 1 in every 11 households in Suffolk home to a UK armed forces veteran, it is important to consider the impact smoking may have on their health. Smoking cessation is the single most effective measure which can be taken to improve veterans' health, and every effort should be made to reduce the burden of preventable smoking-related diseases.

Homeless

Smoking rates are high amongst adults accessing homeless support services, with rates ranging between 57 and 82%[70]. The harms caused by tobacco smoking are likely to be aggravated in this group due to higher prevalence of chronic obstructive pulmonary disease (COPD), heart problems and respiratory viral illness[71,72]. With these factors in mind, people who smoke and who access homelessness services represent a key group in need of smoking cessation interventions. Homeless support services may be a useful place to support smoking cessation as many professionals already have good relationships with their service users and there is an established foundation for offering support. However, to date, there is little published literature on how smoking and cessation is treated and managed across homeless services in the UK.

Due to the complex nature of homelessness and needs of the people experiencing homelessness, research shows that smoking takes a low priority in the assessment of heath needs[70,73,74]. Additionally, in some cases nicotine has been wrongly viewed as beneficial for the homeless population, because it is perceived as stress relieving and providing comfort[74,75]. However, in 2019, a cross sectional survey of 283 adult smokers accessing support services in Kent, the Midlands, London and Edinburgh highlighted that 75% of participants expressed a desire to quit smoking[76]. With this in mind several studies have reported that many attempts are unaided indicating a lack of utilisation of evidence-based treatments[77–79]. Research has also shown that this disadvantaged group may have limited contact with Stop Smoking Services (SSS), which are free to access and offer behavioural support and licensed stop smoking medication[6]. This reduced access may discourage those on low incomes from committing to quitting long-term.

Qualitative work has shown that e-cigarettes are viewed more positively by people considering quitting smoking while experiencing homelessness and are favoured over more medicalised approaches because they offer a less structured and less formal approach to continue using nicotine without the harms of smoking tobacco[76]. For homeless services already offering established substance harm reduction interventions (e.g., safer injecting equipment, condoms, opioid substitution therapies), e-cigarettes may ft well with this model, as they likewise offer a less harmful way to use a substance while reducing associated risks[6]. This is in line with the National Institute of Health and Care Excellence (NICE) guidance[27] who recommend that nicotine containing e-cigarettes and vapes should be accessible to all adults who want to quit smoking.

If a person is threatened with homelessness, the local authority has a duty to help prevent them from becoming homeless (termed prevention duty). If a person is already homeless, the local authority has a duty to help them secure accommodation for at least six months (termed relief duty).

In Suffolk, the number of households recorded as homeless has remained stable, with 3,795 households in 2022/23 owed either a prevention or relief duty. In Suffolk in 2022/23, 1,525 households were recorded as

homeless and received a relief duty. Over 1 in 3 (n =570, 37.4%) of those in Suffolk receiving a relief duty received the duty from West Suffolk.

The Suffolk districts and boroughs ranked by number of homeless households (and owed a relief duty) in 2022/23 were:

- West Suffolk (570)
- East Suffolk (396)
- Ipswich (331)
- Babergh (123)
- Mid Suffolk (105)

Prisoners

Worldwide, the prevalence of smoking among the prisoner populations is between two and eight times higher than the general population[80]. NHS England is responsible for commissioning healthcare for people in prisons[81]. However, smoke-free policies have been increasingly widely introduced to protect staff and prisoners from exposure to high levels of secondhand smoke (SHS). On the 29th of September 2015, it was announced by the government that all prisons in England and Wales would be going smokefree. At the end of October 2015 all open (category D) prisons went smokefree indoors, and a process was started for rolling out smokefree policies indoors and out in closed prisons. The process was completed in July 2018, by which time all closed prisons in England and Wales were smoke free, a total of 103 prisons in England and 3 in Wales, with accommodation for over 82,000 prisoners[82].

For prisoners who smoke, smoking cessation support (including up to 8 weeks of behavioural and pharmacological support with NRT) will be offered[83]. Prisoners were also able to purchase electronic e-cigarettes and vapes from the prison shop (known as "canteen"), one being a single-use disposable product and the other a rechargeable vape pen with pre-filled capsules containing up to 18 mg of nicotine and available in several flavours. Within the closed prison estate prisoners are only permitted to vape in their cell whereas in the open estate, alongside being allowed to vape in their cell, prisoners are also permitted to vape outside in designated vaping shelters[84]. However, tobacco does still circulate through the informal economy, also referred to as the illicit or underground economy. Prison violence for tobacco is also quite high due to the demand and scarcity of the product[85].

Research has shown that "complete" smoke-free prison policies (no smoking allowed within the perimeter wall, inside and outside of buildings by prisoners and staff) tend to be more successful than partial smoking restrictions (smoking allowed by prisoners and sometimes staff in 1 or 2 areas within the prison perimeter, usually prison cells or outside exercise yards)[86,87].

More recently, a study investigated stakeholders' views on the implementation and delivery of complete and partial smoke-free policies, specifically in relation to the management of nicotine addiction throughout sentence and after release[88]. Results found that the smoke-free implementation across the closed prison estate was viewed as a success, though there were reports of reduced availability of smoking cessation support since the roll out. Participants thought the majority of tobacco smokers living in closed prison environments were now using vapes as a temporary means to manage nicotine addiction until release. In open prisons the partial policy has been less successful; high rates of smoking resumption on moving from closed to open conditions was reported, with many participants arguing that the open estate should also go completely smoke free. It was envisaged that most prisoners would resume smoking upon community release. This shows that smoke-free policies provide a unique opportunity to promote lifelong cessation in this disadvantaged group. However, more could be done to adopt a consistent smoke-free policy across all prisons, and to support prisoners in quitting smoking and nicotine use during and after imprisonment.

There are three prisons in Suffolk- HMP Hollesley Bay, HMP Highpoint and HMP Warren Hill. Two of the prisons (Highpoint and Warren Hill) are category C prisons, while Hollesley Bay is category D. All prisons in Suffolk adhere to the UK smoke free policies. In the most recent unannounced inspection of Hollesley Bay

(22nd October – 1st November 2018)[89] it was also noted that the overall governance of health services was effective and links to the prison were good. However, in line with research, it was noted smoking cessation services were available to all prisoners, but the waiting time was too long at 19 weeks. During the inspection, health services staff contacted all those on the waiting list to ascertain their continued need and review the process. It was assured that access to services would be addressed by the wellbeing practitioner in the near future.

LGBTQ+

Smoking prevalence is higher among lesbian, gay, bisexual, transgender, intersex, queer/questioning (LGBTQ+) people than in the general UK population. This is despite smokers within the LGBTQ+ community wanting to quit and making the same number of quit attempts as the general population[90]. While there is currently limited data on smoking prevalence in trans and non-binary populations, the data available suggests that smoking prevalence is also higher[91].

The 2018 annual population survey (APS) contains the latest available data collected regarding sexual orientation and smoking. The survey reported that the proportion of current smokers was significantly higher among people who identified as gay or lesbian (22.2%) than heterosexual (straight) people (15.5%)[37]. Similar findings were shown in the 2022 GP survey[66]. Gay or lesbian and bisexual patients were more likely to have said they were regular smokers. The survey reported that 11.2% of people who identified as gay or lesbian, and 10.1% of those who identified as bisexual said they were regular smokers, compared to 6.9% of those who identify as heterosexual.

While there is very limited research into why LGBTQ+ smoke, it is likely related to the discrimination and prejudice LGBTQ+ people face as a result of their sexual orientation or trans status. There is still a significant prevalence of homophobia, biphobia and transphobia in schools, the workplace, and healthcare services. LGBTQ+ people may not be out to their family or may be estranged from them because of their sexual orientation. LGBTQ+ people still face high levels of hate crime, most of which goes unreported. These experiences can result in high stress levels, sometimes referred to as minority stress[92]. Minority stress theory proposes that sexual minority health disparities can be explained in large part by stressors induced by a hostile, homophobic culture, which often results in a lifetime of harassment, maltreatment, discrimination, and victimisation and may ultimately impact access to care[93].

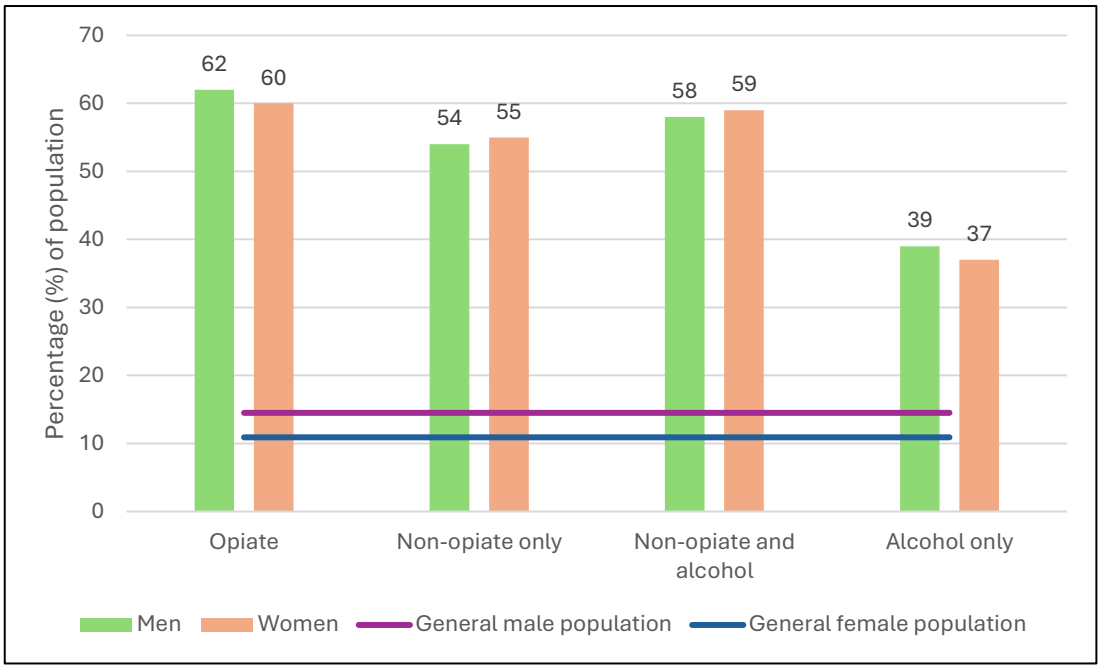
LGBTQ+ people also face problems accessing health services. In January 2016 a report by the Women and Equalities Select Committee into 'transgender equality' concluded that "the NHS is letting down trans people" noting a number of areas such as a lack of staff training around gender identity and a failure to combat transphobia[94].

The 2021 census showed that the percentage of the population aged 16 and over that self-identify as being gay or lesbian is 1.3%, similar to the percentages seen in the East of England region (1.2%), but slightly lower overall than the England national percentage (1.5%). The percentage of the population aged 16 and over that self-identity as being bisexual is 1.1%, similar to the percentages seen in the East of England region (1.1%), but slightly lower overall than the England national percentage (1.3%). Among Suffolk Lower Tier Local Authorities, Ipswich had the highest rates of people aged 16 and over reporting that their sexual orientation was either gay or lesbian (1.5%), bisexual (1.6%) or pansexual (0.4%)[95].

People with substance misuse conditions

Figure 21 shows the national smoking rates at the start of substance misuse treatment for both males and females, between April 2022 and March 2023, compared to the general male and female population as reported in the Adult substance misuse treatment statistics report[96]. Results show that, across all substance groups, men and women reported smoking at similar levels. In all cases, the level of smoking was much higher than the general adult smoking rate in England. Despite the high levels of smoking, only 4% of people were recorded as having been offered referrals for smoking cessation interventions, the same proportion recorded in 2021 to 2022[96].

Figure 21: Percentage of smokers at the start of substance misuse treatment; April 2022 to March 2023



Source: OHID

Additionally, as discussed in the data & intelligence section of this health needs assessment, Population Health Management (PHM) descriptive analysis showed that between December 2022 and November 2023 in SNEE ICB, over half (51%) of individuals with substance abuse also have a recorded history of smoking (within the last year).

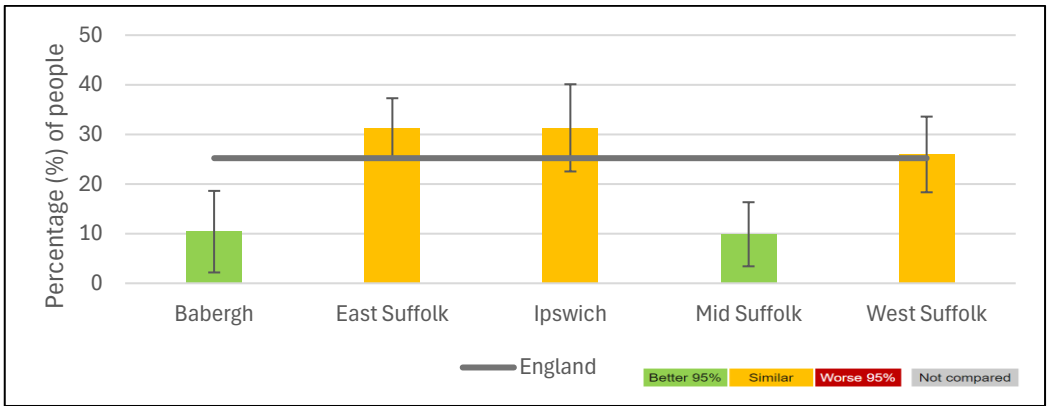
Smoking tobacco may also inhibit the ability to stop using other drugs, particularly where they are commonly consumed alongside tobacco, such as cannabis[97]. It is therefore plausible that addressing smoking and addictions to other substances will improve outcomes for both. There have been concerns that supporting people to quit smoking may reduce their ability to respond to treatment for other addictions. However, providing stop smoking support to people in treatment for drug and alcohol addictions does not affect abstinence rates and positively impacts smoking cessation rates[98].

People with mental health conditions

Under the Equality Act 2010, a mental health condition is defined as 'long-term' if it lasts, or is likely to last, 12 months[99]. In Suffolk, (2021/22) it was estimated that over 1 in 4 (25.9%) of adults (aged 18 years or over) with a long term mental health condition smoked, this is statistically similar to the England estimate of 25.2%[100].

Figure 22 shows the smoking prevalence in adults with a long-term mental health condition across Suffolk districts, compared to England, for 2021/22. Results show that East Suffolk and Ipswich had the highest smoking prevalence among those with a long-term mental health condition, both with an estimated prevalence of 31.3%. West Suffolk had an estimated prevalence of 26.0% - also statistically similar to the England estimate. Both Babergh and Mid-Suffolk have statistically significantly lower smoking prevalences among those with a long-term mental health condition when compared to England, with estimated prevalences of 10.4% and 9.8%, respectively.

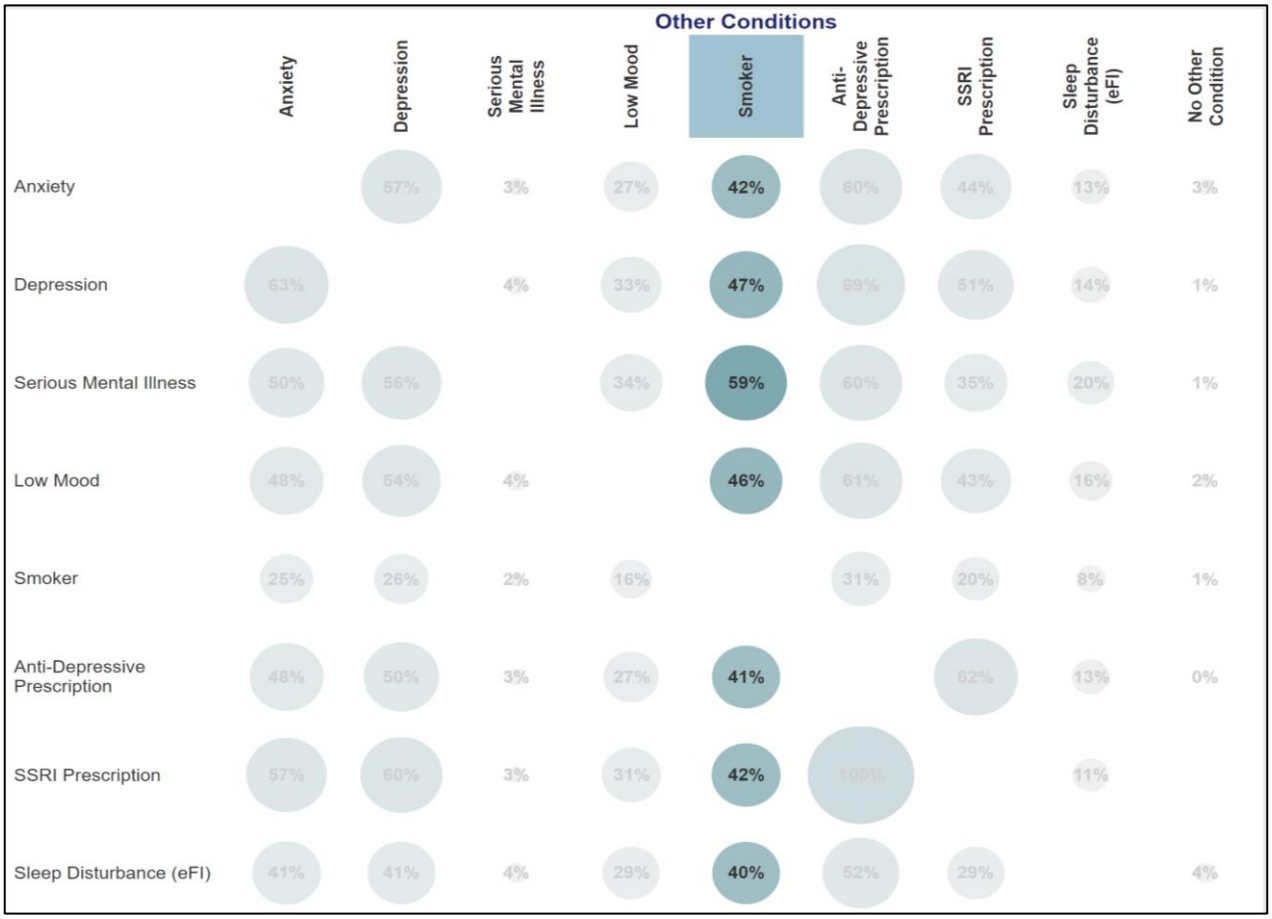
Figure 22: Smoking prevalence in adults with a long term mental health condition (18 years and over)- current smokers (GPPS), across Suffolk districts, compared to England, 2021/22



Source: Fingertips

Additionally, figure 23 presents a bubble matrix showing the percentage of people who have a history of smoking (in the last year) who are also affected by selected conditions associated with mental health and/or low mood at ICB level for December 2022 to November 2023. Results show that over half (59%) of people diagnosed with a serious mental health condition smoke. Additionally, around half of people diagnosed with depression (47%) or a low mood (46%) smoke. Over 1 in 3 people with anxiety (42%), with a SSRI prescription (42%), with an antidepressant prescription (41%) or suffering from sleep disturbance (40%) smoke.

Figure 23: Bubble matrix showing the percentage of people who have a history of smoking in the last year who are also affected by selected conditions associated with mental health and/or low mood; for SNEE ICB, December 2022 - November 2023



Source: PHM Dashboard Descriptive Analysis

Pregnancy

Smoking during pregnancy is the leading modifiable risk factor for poor birth outcomes, including stillbirth, miscarriage, and pre-term birth[101,102]. Smoking during pregnancy also increases the risk of children developing several respiratory conditions, attention and hyperactivity difficulties, learning difficulties, problems of the ear, nose and throat, obesity, and diabetes[101,103,104]. This is because smoking during pregnancy, or exposure to second-hand smoke (SHS), restricts oxygen to the baby causing its heart to work faster and exposing it to harmful toxins[105].

Table 13 shows the impact of smoking and exposure to second-hand smoke during pregnancy as reported by The Royal College of Paediatrics and Child Health (RCPCH)[106].

Table 13: Impact of smoking and exposure to second-hand smoke during pregnancy

	Maternal smoking	Second-hand smoke exposure
Low birth weight	2 times more likely	Average 30-40g lighter
Heart defects	25% more likely	Increased risk
Stillbirth	47% more likely	Possible increase
Preterm birth	27% more likely	Possible increase
Miscarriage	32% more likely	Increased risk
Sudden Infant Death	3 times more likely	45% more likely

Source: ASH

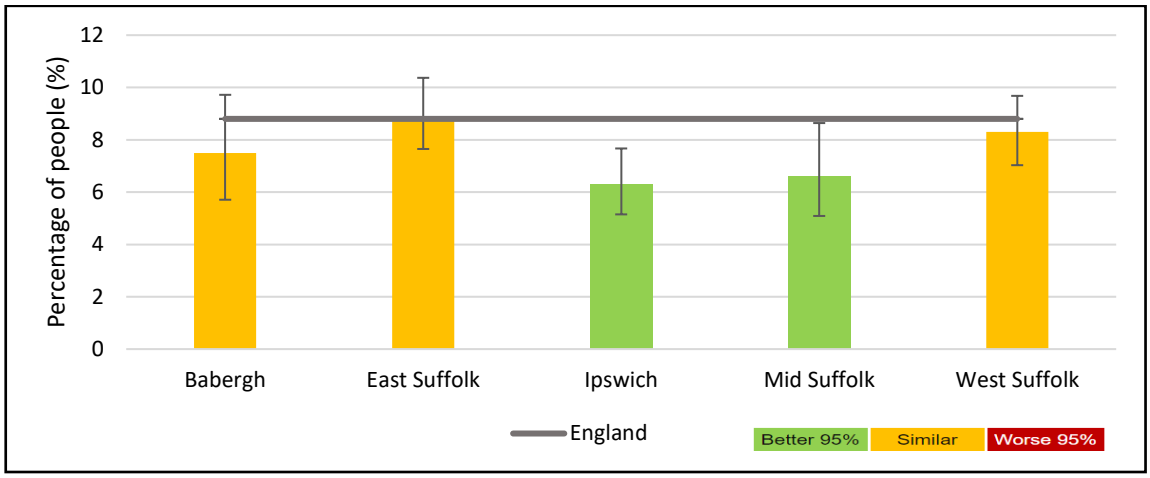
In December 2021, ASH published a Smoking, pregnancy, and fertility fact sheet. The fact sheet provides detailed information on the health implications of maternal smoking and second-hand smoke exposure. Smoking during pregnancy has well known detrimental effects for the growth and development of the baby as well as the mother including: complications in pregnancy, stillbirths, neonatal death and serious long-term health implications for both mothers and their babies[107].

There are big variations in maternal smoking rates, depending on age, geography, socio-economic status, and ethnicity[47,106]. Women from disadvantaged backgrounds are more likely to smoke before pregnancy; less likely to quit in pregnancy and, among those who quit, more likely to resume after childbirth[108,109]. The infant feeding survey conducted in the UK, reveals 40% of mothers in routine and manual occupations were the most likely to have smoked before or during pregnancy compared to mothers in managerial and professional occupations (14%)[110], results from the infant feeding survey 2023 will be published on GOV.UK when available[111]. Younger women are also more likely to smoke during pregnancy. In 2022/23 20.8% of women aged under 20 were current smokers at their booking appointment compared to 6.8% of women over the age of 40[112].

Pregnant women are also more likely to smoke if they are less educated, live in a community with high smoking rates, single or have a partner that smokes[47,109]. Women who live with a smoker are six times more likely to smoke throughout pregnancy. Additionally, those who live with a smoker and manage to quit are more likely to relapse once the baby is born[105,110].

In Suffolk, 2022/23, 7.7% of women were smoking at the time of delivery, statistically significantly lower than the England estimate of 8.8%. This equates to 480 babies born to smokers in Suffolk each year. Figure 24 presents the number of mothers known to be smokers across Suffolk districts, compared to England in 2022/23. Results show that Ipswich has the lowest proportion of mothers smoking at the time of delivery with an estimate of 6.3%, statistically significantly lower than the England estimate. This is closely followed by Mid Suffolk with an estimate of 6.6%, also statistically significantly lower than the England estimate. East Suffolk has the highest proportion of mothers smoking at the time of delivery with an estimate of 8.9%, statistically similar to the England estimate. This was closely followed by West Suffolk (8.3%) and Babergh (7.5%), both statistically similar to the England estimate.

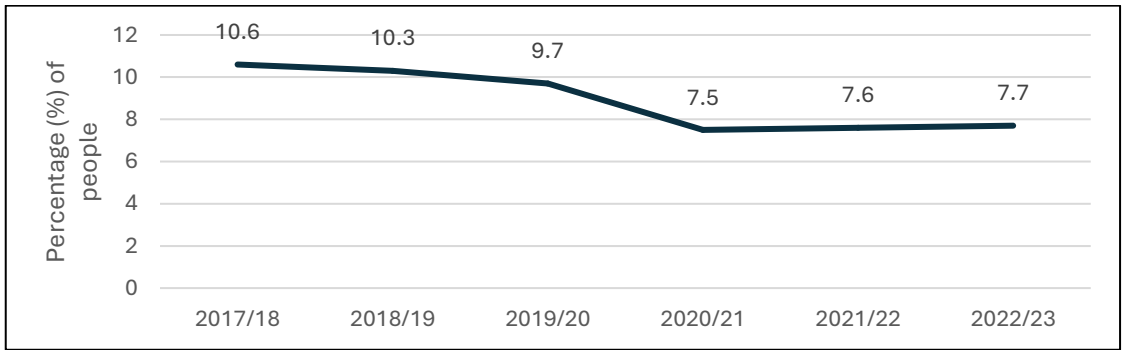
Figure 24: The number of mothers known to be smokers at the time of delivery as a percentage of all maternities with known smoking status, across Suffolk districts, compared to England, 2022/23



Source: Fingertips

Figure 25 shows the percentage of mothers known to be smokers at time of delivery in Suffolk over time, between 2017/18 to 2022/23. Results show that Suffolk's proportion of mothers known to be smokers at the time of delivery has decreased by 2.9 percentage points from 10.6% (2017/18) to 7.7% (2022/23).

Figure 25: Percentage of mothers known to be smokers at time of delivery in Suffolk, between 2017/18 and 2022/23



Source: LG Inform

In the 2017 Tobacco Control Plan for England set a target of reducing the prevalence of smoking during pregnancy to less than 6% by 2022, measured as smoking at the time of delivery (SATOD)[113]. Results highlight that overall both England (8.8%) and Suffolk (7.7%) have missed this goal[114]. Modelling done by the Smoking in Pregnancy Challenge Group shows that the 6% target won't be reached until 2032 if maternal smoking rates continue to decline at the same rate they have since 2015[106]. In April, the Government announced a national financial incentive scheme which will be offered to all pregnant women who smoke by the end of 2024. The incentive aims to be in the form of vouchers and will run alongside behavioural support[115].

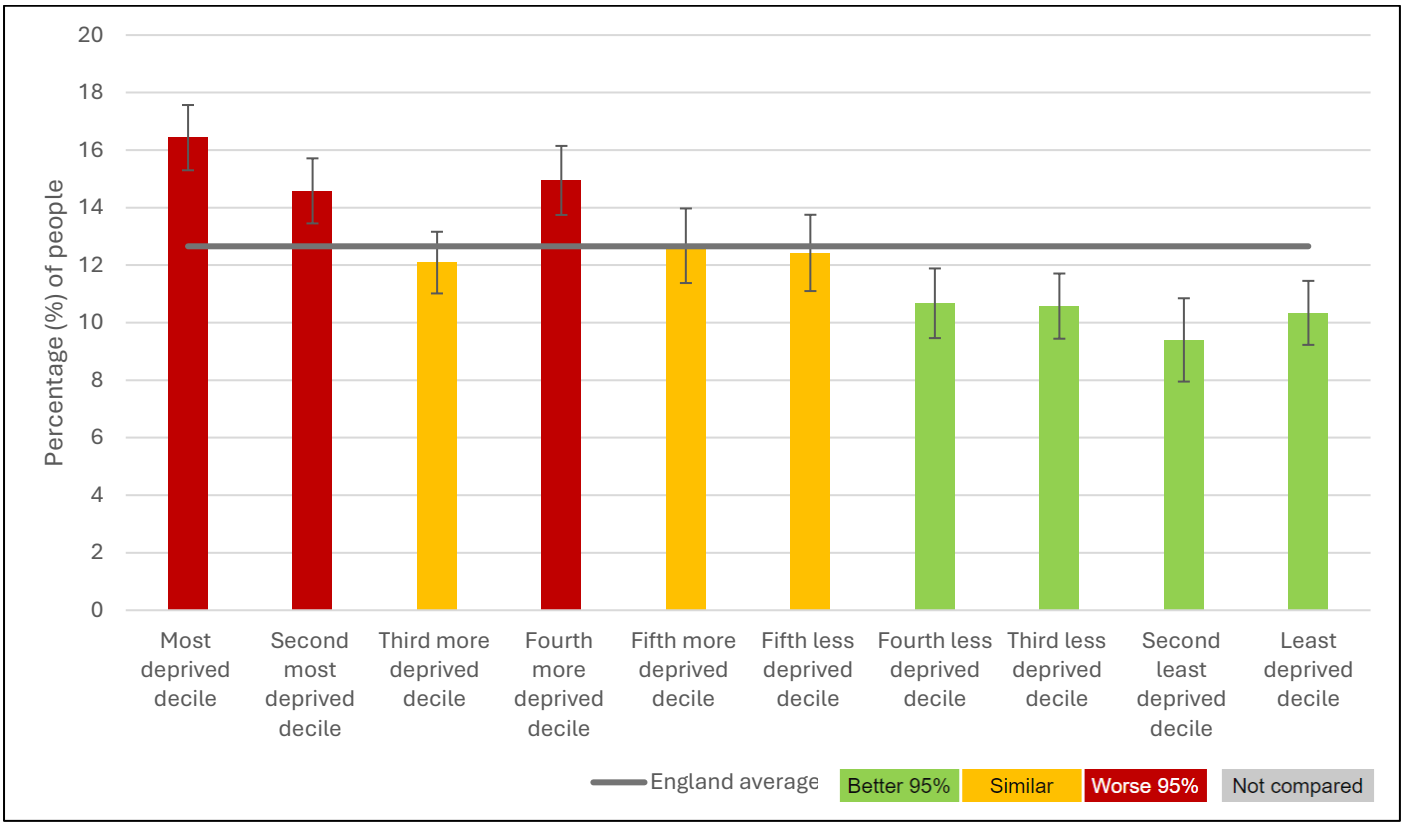
Deprivation

The English Index of Multiple Deprivation (IMD) was published in 2019. The IMD provides a way of comparing relative deprivation across England using seven domains: income, employment, health and disability, education, crime, barriers to housing and services, and the living environment.

Areas with higher levels of deprivation tend to have a greater prevalence of smoking among their residents. Individuals living in the most deprived areas often face a heavier burden of illnesses and poorer health outcomes compared to those residing in more affluent areas. Figure 26 shows the national smoking

prevalence in adults aged 18 and over by deprivation, compared to the England average. Results show that on a national scale, the smoking rate among people belonging to the most deprived socioeconomic deciles stands at 16.2%, statistically significantly worse than the England average (12.7%). Smoking prevalence in the second (14.6%) and fourth (14.9%) most deprived areas were also statistically significantly worse than the England estimate. On the other hand, those in the least deprived deciles exhibit a lower smoking prevalence of 9.8%, statistically significantly better than the England estimate. Smoking prevalence in the second (9.4%), third (10.6%) and fourth (10.7%) least deprived deciles were also statistically significantly better than the England average.

Figure 26: National smoking prevalence in adults aged 18 and over by deprivation, compared to the England average, based on the Annual Population Survey for 202

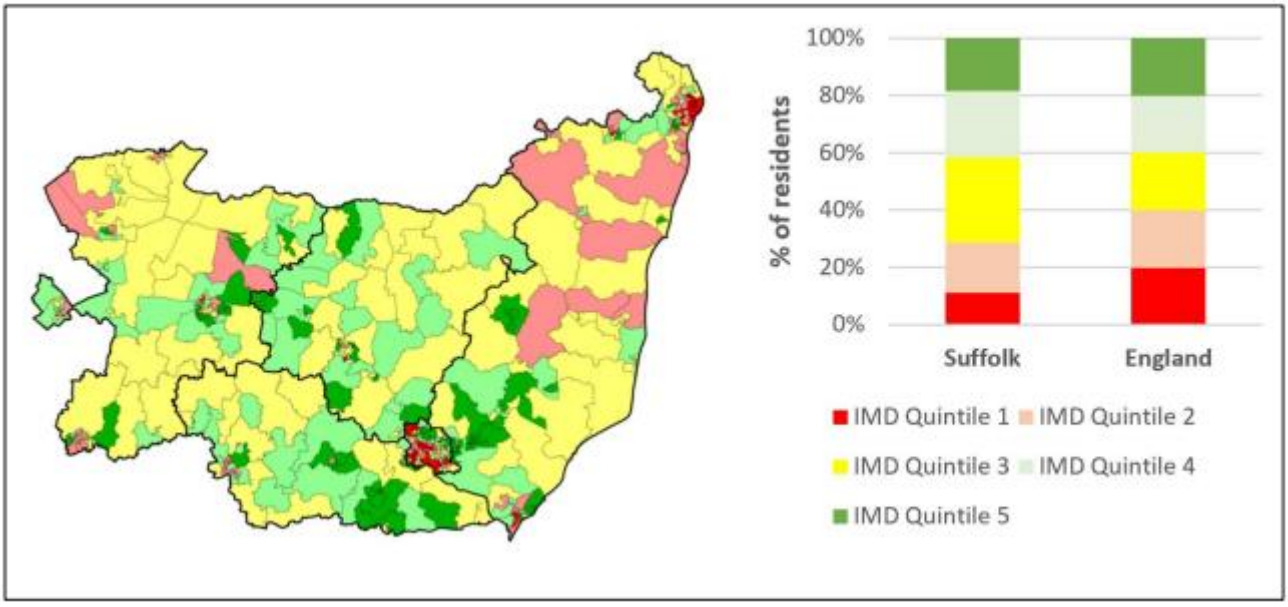


Source: Fingertips

Figure 27 maps the IMD scores across all Lower Super Output Areas (LSOAs) in Suffolk and provides a comparison of the proportion of the population in specific levels of deprivation to that of England. The IMD quintile 1, shown in red, represents local areas in the most deprived 20% within England and the IMD quintile 5, shown in green, represents local areas in the least deprived 20% within England.

Results show that over a quarter (29.7%) of Suffolk residents fall within IMD Quintile 3. However, 11.3% of LSOAs fall within the IMD Quintile 1 and these Suffolk LSOAs within the top 20% most deprived areas nationally are situated primarily within Lowestoft and Ipswich. This equates to an estimated 10.5% of Suffolk's population (around 80,200 people) living in neighbourhoods ranked among the 20% most deprived in England.

Figure 27: Suffolk IMD map by LSOA area and IMD quintile comparison to England



Source: English indices of deprivation 2019

Socioeconomic status

"Socioeconomic status" refers to a method of assessing the resources groups of people can draw upon. It often reflects education, income, work conditions, employment relations and job role. It is known that people living in socially and economically deprived areas are less likely to be in work and are also more likely to smoke[116]. A meta-analysis of 29 longitudinal or cohort studies investigated the relationship between smoking and work absenteeism. The study concluded that smokers were 33% more likely to be absent from work with smokers taking an average of 2.74 additional days of sick leave per year compared to non-smokers[117].

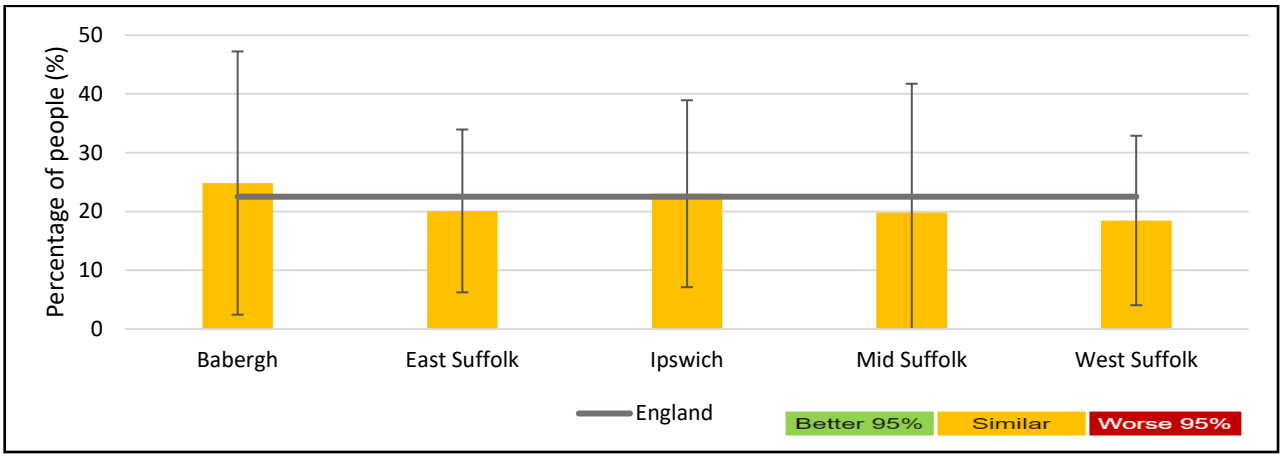
It is estimated that 25.6% of all smoking households in the region of East of England fall below the poverty line after smoking expenses are considered. This represents around 15,000 households with a smoker in Suffolk[118]. Nationally, current smokers are 5% less likely to be employed than non-smokers and long-term smokers are 7.5% less likely to be employed. In Suffolk 2,900 people are estimated to be out of work due to smoking[119,120].

Routine & manual workers

The Office of National Statistics (ONS) uses a set of groups linked to occupation to show socioeconomic status. Literature has also shown that individuals in the ONS 'Routine and Manual occupation' classification (characterised as having lower incomes than the national average and living in areas of social deprivation) are far more likely to smoke and less likely to become ex-smokers[121–123]. Consequently, smoking plays a significant role in contributing to health inequalities between socio-economic groups.

Figure 28 shows the smoking prevalence in adults in routine and manual occupations across Suffolk districts compared to England. Results show that in 2022, all Suffolk districts had a statistically similar smoking prevalence in adults in routine and manual occupations (18-64) when compared to the England estimate of 22.5%. Babergh has the highest prevalence of smokers in adults in routine and manual occupations with an estimate of 24.8%. This is closely followed by Ipswich and East Suffolk with estimates of 23.0% and 20.1%, respectively. Mid Suffolk has an estimate of 19.8%, and West Suffolk has the lowest smoking prevalence in adults in routine and manual occupations with an estimate of 18.5%.

Figure 28: Smoking prevalence in adults in routine and manual occupations (18-64) - current smokers, across Suffolk districts, compared to England, 2022



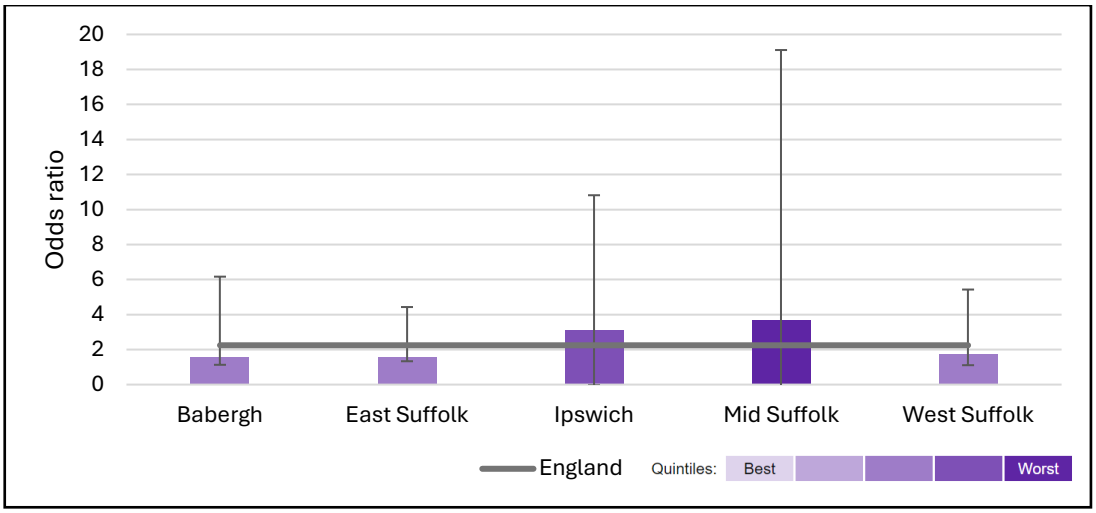
Source: Fingertips

Figure 29 shows the odds of those with a routine and manual occupation reporting current smoking status compared to individuals with other occupations, across Suffolk districts, compared to England. The odds ratio for this indicator represents the odds that an event (smoking) will occur in the presence of a certain exposure (having a routine or manual occupation), compared to the odds of the same event (smoking) occurring in the absence of the exposure (having a routine or manual occupation).

An odds ratio higher than 1 signifies the group with routine and manual occupations are more likely to smoke than their counterparts. For example, if the odds ratio is 2, they have twice the odds of smoking. On the other hand, an odds ratio between 0 and 1 signifies that they are less likely to smoke. For example, if the odds ratio is 0.5, they have half the odds of smoking. In 2022, individuals in routine and manual occupations across England were are 2.24 times more likely to be smokers compared with other occupations[124].

Individuals in routine and manual occupations in Mid Suffolk were 3.7 times more likely to be smokers compared with other occupations. This was closely followed by Ipswich where routine and manual workers were 3.1 times more likely to be smokers. Routine and manual workers in West Suffolk were 1.8 times more likely to smoke, and routine and manual workers in both Babergh and East Suffolk were 1.6 times more likely to smoke. Although this may highlight the socioeconomic gap in current smokers across Suffolk districts the confidence intervals are large decreasing the reliability of results.

Figure 29: Odds of current smoking (self-reported) among adults aged 18-64 with a routine and manual occupation, across Suffolk districts, compared to England averages, 2022



Source: Fingertips

In general, smokers in the routine and manual socio-economic group try to quit as often as their peers in the professional and managerial group, but they do not succeed as often[125]. This is partly because they are more dependent on nicotine: they start smoking earlier in the day, smoke more cigarettes per day[126] and consume more nicotine per cigarette than the most affluent smokers[127] Research indicates factors that can affect their chances include[128]:

- **A lack of social support**: Smokers who are trying to quit benefit from continuing, non-directive social support, which may be harder to find when smoking is more common and more acceptable within family and community. Long-term abstinence is also harder for ex-smokers if they routinely find themselves in the company of smokers, especially if they experience social pressure to smoke.
- **A focus on present needs over future plans:** People in low socio-economic groups tend to be more focussed on the present and are more likely to be motivated by immediate health concerns. They are less likely than people in high socio-economic groups to be motivated to quit by a concern for health in the future.
- **Stress and boredom**: People who experience enduring stress may turn to smoking to cope and may feel that quitting is a low priority, given the rest of life's daily concerns.
- **Failure to adhere to treatment**: Smokers in low socio-economic groups are more likely to stop taking treatment early and less likely to complete programmes of behavioural support.

In September 2023 routine and manual workers in Suffolk were invited to participate in informal interviews on the topic of smoking. Consent was obtained for anonymous use for insight purposes. Key findings included:

- **Starting smoking:** Many interviewees started smoking when young, typically secondary school age, with peer pressure and social norms key contributors to starting smoking. Often people were not thinking about long term impacts of smoking but have become addicted.
- **Smoking:** Respondents tended to smoke more when they feel stressed, anxious, worked up or upset. There were also perceived generational differences in smoking habits (i.e. young people seeing how much it costs, older generation being influenced at school, and by parental / wider family habits).
- **Vaping:** There were different levels of knowledge about harms of vaping, also a general dislike of vapes, with an acknowledgement that children and young people are likely drawn to the flavours.
- **Quitting:** Key motivators for quit attempts were health related- e.g. pregnancy, getting an operation or procedure. Barriers to successful quitting included weight gain, the social element of smoking (i.e. with a drink). An interesting insight that one respondent felt that smokers and drinkers were actually funding the NHS, and the individual seemed resistant to the thought of quitting.
- **Services:** There was confusion / lack of knowledge around Allen Carr's Easyway (thinking they interviewer was referring to the comedian). Online support was favoured, as were one to one methods to support quitting.
- **Old behaviour change methods are dated and not working:** The current quit methods are dated- messages about poor dental health, or damaged lungs pictured on cigarette packets have little impact on people wanting to quit. One respondent noted that they rarely visit the doctor- and get a lot of information via Facebook and TikTok.

Interview feedback summarised into core theme areas can be found tables 1 & 2 in appendix 4. Where possible direct quotes have been used, this includes the use of one expletive.

The project to reduce smoking in the routine and manual workforce in Ipswich included stop smoking interventions. For the period of delivery in 2024, 125 smokers in 3 businesses set a quit date. Using the behaviour change COM-B model the project created a high uptake of the project stop smoking offer. The project worker giving stop smoking advice was present at times and places that suited the workers (during out of hours shifts, weekends, breaktimes and where the smokers work) and having free vapes kits available provided the **opportunity** for routine and manual workers to access a stop smoking intervention and to make a quit attempt. Being face to face, project worker was able to assess **capability** and assist offer

immediate and ongoing assistance. The project officer being present for several hours, being visually present created a word or mouth referral from smoking colleagues, the offer to all smoking colleagues (not just R&M workers), and having vapes to give out on the stop, helped with **motivation.** There was a low response to the request to share if the smoker quit. This maybe been due to the method of quit data recovery and a delay in this reaching the smokers. The project is introducing more options for people to engage at a more intensive level of support and the project officer will be having direct text contact in a timely manner to acquire quit data.

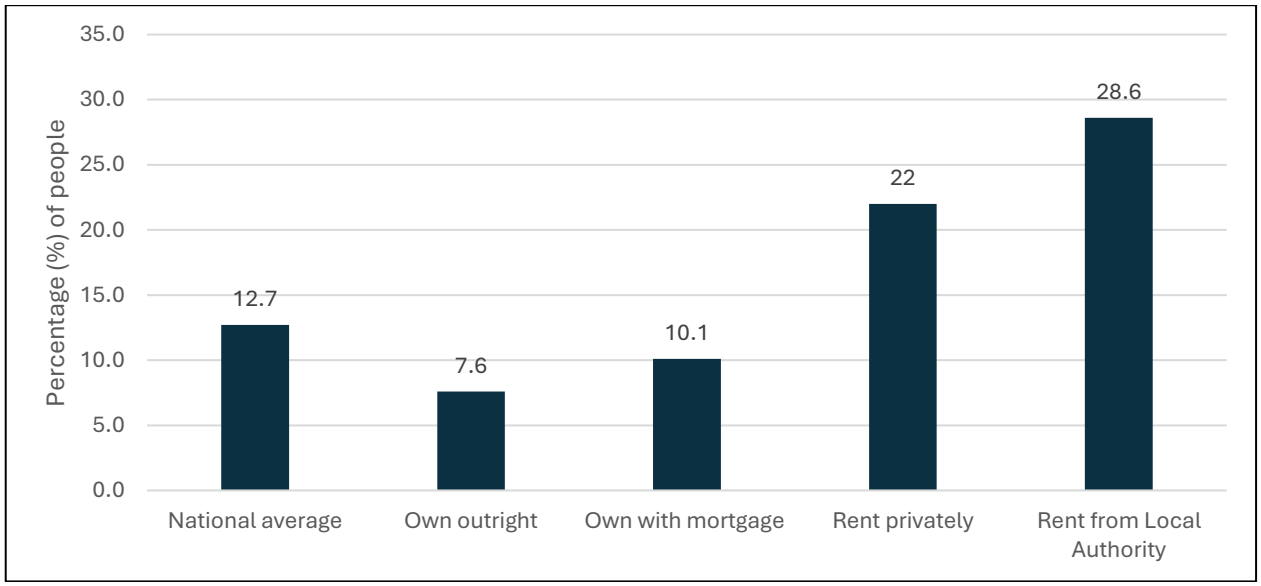
Housing tenure

Of all the socioeconomic measures, a person's housing tenure is now the strongest independent predictor of smoking in England[129], with the highest levels of smoking found among people living in social housing. Rates in social housing are estimated to be between 30%[130] and 33%[129] - almost 3 times higher than among people who own their home and more than double that of the general adult population[130].

Housing is recognised as a determinant of health. By providing high-quality, well-built, and maintained homes, social housing providers are a key partner in protecting and improving the physical and mental health of the population. However, the provision of high-quality, well-built homes is not the only way social housing providers can support their residents[131].

Figure 30 presents the percentage of the population who are smokers, by type of housing , for England, 2021[40]. Results show that, nationally, over one in four people living in social housing smoke (28.6%) this is over double the national smoking rate (12.7%) and around four times the smoking rate for people living in a house the own outright (7.6%).

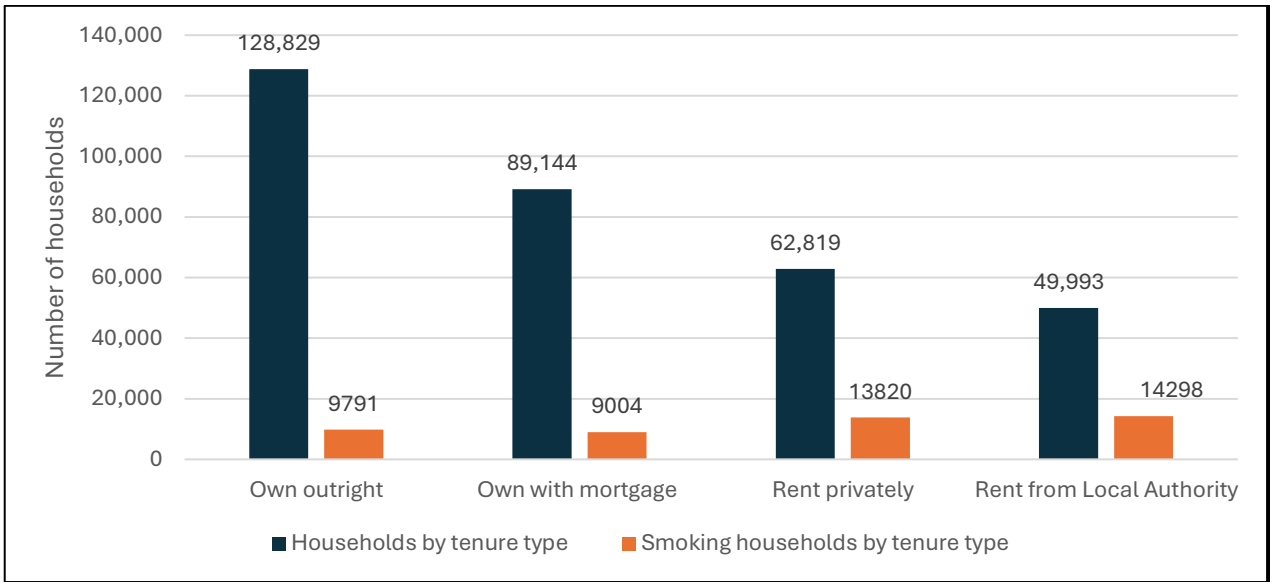
Figure 30: The percentage of the population who are smokers, by type of housing, for England, 2021



Source: Office for National Statistics

Figure 31 provides the count of smoking households by tenure for Suffolk and the number of smoking households calculated via the extrapolation of the national percentages of the population who are smokers by type of housing. Results show that, in Suffolk, smoking prevalence is highest in households rented from local authority with an estimated 14,298 households. This is closely followed by households rented privately with an estimated 13,820 households. Both owned outright and owned with a mortgage households have lower smoking prevalence with an estimated 9,791 and 9,004 households, respectively.

Figure 31: Number of households by tenure type in Suffolk compared to the estimate number of smoking households by tenure type in Suffolk, 2021



Source: Office for National Statistics

Additionally, the impacts of second hand smoke (SHS) in the home have been known for decades[132]. In the early 2000's the Royal College of Physicians published a set of papers[55] which found that over 20,000 cases of lower respiratory tract infection, 120,000 cases of middle ear disease, and at least 22,000 new cases of wheeze and asthma were all caused by SHS (also termed passive smoking) in children each year in the UK[133]. Additionally, children whose caregivers smoke are more than twice as likely to have tried cigarettes, and four times as likely to regularly smoke. Two thirds of those trying one cigarette will go on to become daily smokers, at least temporarily[134].

It is estimated that 41,100 children in Suffolk live in smoking households, and each year 1,300 children start smoking in Suffolk[49]. With this in mind, social housing providers are increasingly seeking to improve the breadth and depth of support offered to their residents, maximising the social value they deliver. In being connected to where a person lives, they are uniquely placed to support residents in a wide range of areas as part of their housing and asset management; for example, from providing health and wellbeing services to installing smoke detectors or sprinkler systems, and from offering financial advice to supporting career development or addressing worklessness.

In 2022, ASH conducted research with social landlords and found that many are actively engaged in trying to better support their residents to reduce tobacco use as part of approaches to improving residents' health. However, this activity is ad hoc, often dependent on the commitment of individuals, rather than from a widely held organisational or sector-wide understanding that smoking is a leading cause of preventable illness and inequalities for their residents[131].

To meet the governments ambition of a smokefree England by 2030 across all population groups[135], a significant reduction in smoking rates among social housing residents is required. A collaborative approach across the NHS, public health, and the social housing sector to share expertise and resources to reduce smoking prevalence in social housing has the potential to deliver on shared ambitions for partners, improving the health and wellbeing of local communities whilst maximizing social landlords' social value. However, ensuring action progresses from projects, which are frequently short-term and not sustained, to consistent and effective action requires greater support. Therefore, embedding tobacco control within the social housing sector presents an opportunity for all partners across the social housing and public health[131].

Vaping

Children & young people

While vaping and the use of e-cigarettes have been promoted as a potential cessation strategy for smokers looking to quit combustible cigarettes, it is important to differentiate between vaping for smoking cessation purposes and vaping as an independent behaviour. Those who take up vaping specifically as an attempt to quit smoking likely have very different motivations, risk profiles, and demographic characteristics compared to individuals who start vaping itself as a new habit, separate from any history of smoking.

Of particular concern is the onset of vaping among children and adolescents who were never smokers to begin with. The predictors and demographics associated with youth vaping initiation point to unique risk factors and motivations distinct from adult smokers using e-cigarettes to quit.

In 2023, a survey conducted by the tobacco control charity Action on Smoking and Health (ASH) found that 3.7% of young people aged 11 to 18 in Great Britain vape regularly[51]. Current evidence indicates that vaping is at least 95% less harmful than smoking[136] but is not harmless, with most vapes containing nicotine[137].

Using nicotine in adolescence can harm the parts of the brain that control attention, learning, mood, and impulse control. Each time a new memory is created, or a new skill is learned, stronger connections – or synapses – are built between brain cells. Young people's brains build synapses faster than adult brains. Nicotine changes the way these synapses are formed[138].

Vaping among children and young people has increased. In 2022, Action on Smoking and Health (ASH) survey data (11 to 18 year olds) showed that vaping prevalence (including occasional and regular vaping) was 8.6% in 2022, compared with 4% in 2021, and 4.8% in 2020[51].

In 2021 the International Tobacco Control (ITC) Youth survey data (16 to 19 year olds) showed that vaping prevalence (defined as vaping on more than 10 days of their lifetime and having vaped in the past 30 days) was 9.1% in February 2021 (compared to 7.7% in August 2019)[6].

Results from the latest 2021 survey of secondary school pupils in England in years 7 to 11 (mostly aged 11 to 15), on vaping show a similar trend. In the UK, the proportion of 11 to 15-year-olds that are currently vaping had increased from 6% in 2018 to 9% in 2021. Although, the rise in current use was not seen for lifetime use. 22% of pupils reported they had ever used e-cigarettes, compared to 25% in 2018 (not a significant change). For girls, prevalence of both regular and current users has increased since 2018.Girls were more likely than boys to be current e-cigarette users; 10% for girls compared to 7% for boys. Regular use was similar (4% for boys and 5% for girls)[60].

The survey also found that the proportion of children who have experimented with vaping has grown significantly since last year (up from 7.7% to 11.6%). In contrast there is no significant change since 2022 in the proportion of children currently smoking (4.8% in 2022 and 3.6% in 2023) or currently vaping (6.9% in 2022 and 7.6% in 2023).

Fears that vaping is leading a whole generation to be addicted to nicotine are not justified by the evidence to date. Most of the 20.5% of young people who have ever vaped have only used a vape once or twice (12.9%), or use vapes less than once a week (3.9%) with 1.8% saying they vape between daily and weekly and 2.0% every day. The majority (63%) of those who have tried vaping once or twice have never smoked, while the majority (71%) of current vapers have tried smoking[51]. This is consistent with evidence from other sources which find that it is more likely that there is a “common liability” in substance use for adolescents[139,140], rather than that vaping is proving to be a gateway into smoking. However, it is important to note that this data is self-reported which could lead to response bias decreasing the validity of results.

Why do children and young people start using e-cigarettes or vapes?

Most youth vaping is experimental. ASH published headline results from its 2023 vaping surveys to inform responses to the government consultation on how to reduce youth vaping[51]. The survey found that the proportion of children who have experimented with vaping has grown significantly since last year (up from 7.7% to 11.6%.

Results also found that nearly three-quarters (73%) of children said their first vape was given to by a friend but for children who currently vape nearly three-quarters (72%) said they usually buy their vapes, most commonly from a corner shop (26%)[141].

'Just to give it a try' is still the most common reason given for using an e-cigarette (40%), followed by 'other people use them so I join in' (19%) then 'I like the flavours' (14%) with a small minority saying they think they're addicted (3.2%)[51].

The role that vaping can play as the most effective aid in helping adult smokers to quit is acknowledged. Only 5.7% of adult never smokers have ever vaped, and only 1.1% of never smokers currently vape, while 11.5% of children 11-17 who have never smoked have ever vaped and 2.3% of never smokers currently vape[51].

The Government strategy is to deliver a smokefree 2030 by "cutting smoking and stopping kids vaping"[25]. However, this strategy could be undermined by the growing misperception that vaping is more than or equally risky as smoking among children- with 54% of individuals believing (this in 2023 up from 41% in 2022), and 39% of adult smokers believing this in 2023 (up from 32% in 2022)[51].

The promotion of e-cigarette and vaping

The growth in vaping is due to the increasing popularity and access of cheap, easy to use and attractively branded single use, disposable vapes. In 2021 current child vapers were least likely to vape disposables (7.7%), in 2022 they became the most used (52%) and use has continued to grow to 69% in 2023. Elf Bar remains the most popular brand, used by twice as many as the nearest competitor Lost Mary (25%) which is made by the same company as Elf Bar, followed by Elux, Geek Bar, and Crystal[51].

The 2023 vaping survey also found that children are most aware of vape promotion in shops which is where exposure has grown most rapidly, up from 37% in 2022 to 53% in 2023. Other sources of promotion are also up but less so, including online (24% in 2022 to 32% in 2023), and buses (9% in 2022 to 11% in 2023) while the change in awareness of promotion on billboards was not significant (12% in 2022 to 14% in 2023)[51].

Evidence indicates that increase in available flavours directly correlates with significant increases in youth vaping, with levels rising from 3.2% in 2021 to 7.6% in 2023. This is highlighted further with 2.3% of children and young people use tobacco flavoured vapes, as opposed to 60% who favour fruit flavours[51]. However, a growing body of evidence suggests that restriction of vapes, including available flavours, significantly decreases overall vape use amongst adults, and causes an increase in cigarette use and increases use of illicit markets[142,143].

Stakeholder engagement: Smoking, vaping, and using tobacco in Suffolk

Healthwatch Suffolk report

During quarter 4 of 2023/24 Healthwatch Suffolk worked with Suffolk's Public Health and Communities team to explore people's experiences of smoking, vaping or using tobacco across Suffolk. This short section summarises the research and its findings. Readers are strongly encouraged to read the full report produced by Healthwatch Suffolk.

The full report is available via the Healthwatch Suffolk website:
https://healthwatchsuffolk.co.uk/smokingreport/

Aim of the research

The research aimed to find out:

- What people understand about the health impacts of smoking, vaping or using other tobacco or nicotine products.
- The key reasons people use those products, and why they started.
- What might motivate people to want to stop, or why they don't want to stop.
- What advice or support people need if they want to quit.
- Whether people are aware of the support available in Suffolk to help them quit.

How the research was conducted

An online web sign-up form was created to gather people's experiences, hosted on the Healthwatch Suffolk website.

- It included an incentivised option for people to sign-up for a limited number of interviews with the Healthwatch Suffolk team, presented as case studies within this report.
- The primary aim of the web form was to recruit, and select, eight people for inclusion as a case study in this research. Case study interviews have yielded a high quality of lived experience data, ensuring engaging and illustrative content for inclusion within the Suffolk JSNA.
- 82 responses received in total, which were then analysed, and 8 people were contacted for more in depth interviews. Findings from the sign up form were also analysed to provide insights.

Summary findings

Key themes identified from the research are highlighted on the page below:

Stress and emotion

- One of the most common themes in respondent's comments in the sign-up form was that they believed smoking or vaping helped them to manage stress or emotion.

Vaping

- Vaping had been a positive tool for many to help them quit. Negative comments about vaping mostly referred to high levels of dependency.
- Respondents frequently rooted this in factors like the social acceptability of vaping, the lack of lingering smell, and that they could be used indoors.
- It was clear that some respondents felt vaping had not helped them to quit. Reasons given for not wanting to quit using vaping included that respondents did not want to switch one addiction for another, or that it did not match the experience of smoking in other forms. Others did not like the flavour or felt it did not adequately address their craving for nicotine. Some current smokers [in the case studies] had concerns about the unknown health impacts of vaping.

Health

- The impact of smoking and vaping on health was a key theme across both the signup form and the interviews. Broadly, respondents were aware of the health impacts of smoking, and nearly two-thirds wanted to quit or had quit for health reasons.

Social influences

- Respondents talked about a diverse range of social influences on their smoking behaviour. Social influences like family, friends and colleagues could provide a reason to start or continue smoking, but they had also been a motivation to quit for some. Key life events such as pregnancy have provided an opportunity to quit, however respondents often went back to smoking after their baby had been born. It is notable that over a quarter of the whole sample had started smoking before age 19.

Cost

- Cost was a smaller theme in the responses. Other factors, like health, appeared to be a more common influence on respondents smoking behaviour. However, for some, cost was a key driver in their decision or desire to quit smoking

NRT and Stop Smoking Services

- Respondent's comments about nicotine replacement therapy (NRT) in the sign-up form were mostly negative. Vaping appeared to be a more popular alternative to smoking for many. A few had found these helpful in making a successful quit attempt. There were relatively few comments about using healthcare or other services to support a quit attempt.

Summary findings from the feedback form

- Many of the responses to the sign-up form said that they had started smoking at a young age (22 respondents, or over 1 in 4 (27%) of the sample). Most did not directly refer to peer or social pressure to start smoking, although four mentioned peers or family as an influence.
- A total of 29 respondents (35%) had quit, or wanted to quit, smoking for health reasons. Their feedback included references to general health or fitness as well as experiences of developing illnesses linked to smoking (such cancer or COPD).
- The main reason given for vaping in the sign-up form appeared to be as a tool to quit smoking. Overall, 58% of respondents who had quit smoking said vaping had helped them stop. Many had tried multiple methods to quit before starting to vape, and some had found it easier to quit using vaping.
- Seven respondents (9%) were concerned about the potential health impact of vaping or the lack of research evidence. One current smoker did not want to use vaping as a tool to quit for this reason.
- Very few respondents had accessed a service to help them stop smoking. Just five mentioned specific services in their response.
- A large proportion of the responses in the sign-up form (31 respondents / 38% of the sample) had used smoking or vaping to manage stress, emotion, or to find time for themselves (including away from their children at times).
- All five women who gave an experience of smoking and maternity in the sign-up form had quit smoking while pregnant. Of these, four had started smoking again at some point after their pregnancy.
- Fourteen respondents to the sign-up form (17%) felt they had experienced a high level of dependency on vaping. This included using a vape more often than cigarettes, or that they felt unable to slow down their vape consumption. For three respondents, this experience was a reason for them not to give up smoking using vaping.

Summary quotes from the in depth interviews

A selection of quotes from the in depth interviews are provided in table 14 below. Names have been changed to maintain anonymity.

Table 14: Quotes from the in depth interviews

About the respondent	A key quote
Tracey is female, 38 and White British. She started smoking at age 17, influenced by the fact that she could smoke inside her workplace at the time and a housemate who was a smoker. Like others, she felt smoking was normalised when she started but now felt more ashamed of her habit because of changing public attitudes. Tracey had tried multiple methods to quit smoking without success. She recognised the health risks of smoking but felt cost would be a key motivator for her to quit. Because of this, she felt messaging around stopping smoking could be targeted at a wider range of influences.	"[Pictures on packets] were shocking when they first came in… but to be honest, I don't even notice them anymore. I'm aware of the risks but I don't think about them as deeply as I should."
Darren is male, White British and aged between 45 and 54. He had smoked for 40 years and lives with a long-term mental health condition, receiving support from services both as an inpatient and in the community. Darren has COPD because of smoking, and strongly advocated for vaping as a safer way to consume nicotine, having used vaping to give up smoking two years ago.	"I'm gonna die at some point from the COPD and that is through smoking, you know… So, yes, I am against smoking and I want to get people away from Smoking."

Caroline is 64, White British and has smoked 'on and off' since she was 18. She had quit smoking around four months prior to her interview. She had been 'ashamed of smoking' and attempted to manage her smoking around her work as a hairdresser to avoid judgment from clients. She was had a negative experience of using vaping as a tool to quit smoking, saying it had increased her dependency on nicotine.	"I don't see the difference between drinking, smoking, shopping, gambling, you know, it is an addiction. So, when it comes to that, I'm sort of much more aware of what I was doing, and I think the awareness of what I was doing has led me to be totally abstinent from nicotine now."
Alexi is female, 26, and moved to the UK from Poland four years ago. She was supported to take part in an interview by an interpreter and answered in a mix of Polish and English. Alexi's daughter is a toddler, and she does not smoke around her to protect her health. She felt that she could give up smoking whenever she wanted to but did not have plans to quit.	"There is nothing anyone from outside could say to make me stop. It has to come from my inside this decision. I need to feel that I really want this, and I am not interested in anyone's opinion about my smoking at the moment."
Katrina is female, White British, and 63 years old. She started smoking at 16 after trying it with her boyfriend. She now smokes about 15 cigarettes a day. When she started smoking, she felt it was normalised and information about the health impacts of smoking had been scarce. Like Darren, Katrina also lives with COPD, and was conflicted about her ability, willpower, and motivations to quit.	"I've got lots of grandchildren and I find it more difficult to keep up with them". "I was the cool Nana who used to roll around the floor with them and, you know, play games with them and all that. I find that far more difficult [now] and that upsets me."
Kris is male, 51-years-old, and is British Asian of Punjabi descent. He started smoking around the age of 15. Like others, he felt influenced by images of smoking on TV and in films, and the norms of smoking in public places like buses, planes, or on the tube. Kris had tried to access support to stop smoking from services in the past, however, he felt this support needed to be more tailored to the individual.	"There's the whole thing around vaping and the lack of regulation. It's almost like a harm minimisation, and I think we're only now seeing, sort of eight years down the line, some of the negative impacts. And I actually, if I want to stop, so I want to stop smoking, you know? I don't, I don't want to minimise. I just don't want to change one habit and learn a new habit and then have to deal with getting off that new habit."
R is male, 41 and from Romania. He has been living in the UK since 2016. R started smoking as a teenager, influenced by his friends in Romania. At that time, there were little regulations or enforcement to prevent young people from buying cigarettes. His parents were smokers, although they disapproved of him smoking at first. R felt he could quit with the right support but had found it difficult to access in his local area (Ipswich).	"…in my situation, I'm in so much pain that I might find out the cigarettes or the smoking might be a quite good relief."
Amy is female, White British, and between 35 and 44 years old. She had started smoking at 15 with a friend. Amy's dad was a smoker and had sadly passed away from cancer a few years ago. She felt angry and remembered conversations between her and her dad when she had first learnt about the dangers of smoking in school aged five. Amy was a professional in a stop smoking service, and like Kris, reflected on the need to tailor stop smoking services to individuals' unique circumstances.	"I don't think that, as a society and in public health, we put enough store on Stoptober, and I think we should probably have another campaign. I know we've got National Stop Smoking Day in March, but it's one day, it doesn't really have that, doesn't pack that punch… But I think it has such a power to it and it inspires people."

Behavioural systems mapping

Suffolk's County Council's Behavioural Science Team used Healthwatch Suffolk's research data from interviews and survey responses, to develop a behavioural systems map. This created a visual representation of the behavioural influences associated with smoking and vaping. The full narrative explaining key behaviours and behavioural influences can be found in appendix 5.

Five broad areas emerged across the themes identified:

1. **Smoking in young people**
    - All case study participants and 27% of survey respondents reported smoking as a young person.
    - Knowledge of the health risks of smoking is likely to positively influence those who are particularly risk averse, value their health, or do not live with people who smoke. However, the effect of educating the health risks to younger people is arguably less effective for less risk averse individuals exposed to smoking in their social networks (e.g., parents, friends).

Rather than focussing on the health risks of smoking, new cessation interventions that challenge the powerful social and psychological traps that keep people hooked on smoking rates could be more effective at discouraging young people to start smoking and encouraging young people to stop smoking - reducing the burden of this behaviour.

2. **Behavioural reinforcing loop- coping mechanisms**
    - People use smoking to cope with stressful life events, and the withdrawal associated with nicotine dependency.
    - Approximately half of the case study participants and 38% of survey respondents had reported using smoking/vaping as a coping mechanism for mental health reasons; they *believe* smoking directly benefits their mental health. Therefore, people can be motivated to maintain their smoking behaviour on the false belief that smoking is directly attributable to coping.
    - The extent to which people attribute *withdrawal* symptoms to stressful life events further complicates the issue – the anxiety arising from withdrawal might not be attributed to nicotine dependency, but to stressful life events. This issue of attribution is particularly significant for those who have successfully quit but then relapse when facing stressful life events.

Finding ways to break the ingrained habits and patterns that reinforce smoking behaviour could increase the effectiveness of smoking cessation efforts. Specifically, addressing these behavioural reinforcing loops could lead to the identification of potential relapse triggering threats; therefore, increasing likelihood of successful quits and reducing chances of relapse.

3. **Motivation, before education- creating a desire**
    - Having a sincere desire to quit smoking is a crucial precursor to actually being able to quit successfully.
    - 35% of participants wanted to quit for health reasons. Therefore, messages focusing on the health risks of smoking would likely resonate with this segment population. However, the findings also imply a sizeable proportion who might be persuaded by other reasons to quit. As noted in smoking with young people, health risk messages targeting adults may not be convincing for those less averse to taking risks with their health.
    - People value self-determination, so it's unsurprising that constant health messaging can trigger reactance/resistance. Continually hammering home smoking health risks can lead to desensitisation, missing the mark with:
        - Those without a current desire to quit.
        - Those who attribute quitting solely to willpower.
    - For these groups, anti-smoking interventions and health risk messages can be perceived as undermining their autonomy and competence to quit on their own terms.

Further investigation is therefore needed to better understand how we instill a desire to quit smoking across the non-risk adverse population without causing reactance.

4. **Personal narrative and self-awareness**
    - General findings across the survey results and case studies showed that changes in behaviour – whether quitting or relapsing – correspond with either heightened self-awareness or one's smoking journey being tied to some personal narrative.
    - The case studies also demonstrate that the influencing factors for smoking vary on a spectrum – individual cases had varying levels of desire, varying levels of understanding on the benefits of quitting, varying experiences with support.
    - However, professional views on smokers can be quite absolute - they smoke, or they don't smoke.

These insights suggest understanding the varying desires, motivations, and opportunities among different smoker groups could allow for customisation of smoking cessation interventions to better target specific needs.

- For instance, focusing on leveraging self-awareness and tapping into the personal narratives/experiences of smokers lacking a strong desire to quit could produce an underlying motivation to quit earlier in their journey.
- For those already wanting to quit, interventions could be optimised for their particular mindset, barriers, and lifestyles.

5. **Inform not misinform- Vaping and NRT**
    - Views on vaping are mixed. On the one hand, some case study participants embraced vaping as an NRT, yet others were anxious about vaping for various reasons (e.g., regulation, safety, behavioural control).
    - 43% of survey respondents had used vapes as an NRT to quit smoking cigarettes.
    - Vaping is effective in its ability to capitalise on the behavioural reinforcement loop associated with the hand-to-mouth behaviour, making it an effective NRT relative to other NRTs, which were generally viewed unfavourably.
    - However, results highlighted there are still challenges around making the switch to vaping.

From this, it is important to generate ways in which to guide smokers to use vaping to quit smoking, and then eventually out of vaping once individuals have successfully stopped smoking. Applying insights previously identified around people's capabilities, motivations and opportunities could increase effectiveness.

Stopping smoking

The benefits of quitting

Quitting smoking is one of the most important actions people can take to improve their health. This is true regardless of age or smoking history. Quitting smoking[144]:

- Improves health status and enhances quality of life
- Reduces risk of premature death and can add as much as 10 years to life expectancy
- Reduces the risk for many adverse health effects, including poor reproductive health outcomes, cardiovascular diseases, COPD and cancer
- Benefits people already diagnosed with coronary heart disease or COPD
- Improves mental wellness
- Benefits the health of pregnant women and their foetuses and babies
- Reduces the financial burden that smoking places on people who smoke, healthcare systems, and society

Over time, people who quit smoking see many benefits to their health. After the last cigarette is smoked, the body begins a series of positive changes that continue for years. Table 15 presents the reduced risks from quitting smoking in comparison to continued smoking.

Table 15: The reduced risks from quitting smoking in comparison to continued smoking over time

Time after quitting	Health benefits
Minutes	Heart rate drops
24 hours	Nicotine level in the blood drops to zero
Several days	Carbon monoxide level in the blood drops to level of someone who does not smoke Lungs are clearing out mucus and sense of taste and smell improves
1 to 12 months	Bronchial tubes start to relax, coughing and shortness of breath decreases, lung function increases by up to 10%. Energy will increase
1 to 2 years	Risk of heart attack drops sharply
3 to 6 years	Added risk of coronary heart disease drops by half
5 to 10 years	Added risk of caners of the mouth, throat, and voice box drops by half. Risk of stroke decreases
10 years	Added risk of lung cancer drops by half after 10-15 years Risk of cancers of the bladder, oesophagus, and kidney decreases
15 years	Risk of coronary heart disease drops to close to that of someone who does not smoke
20 years	Risk of cancers of the mouth, throat, and voice box drops to close to that of someone who does not smoke Risk of pancreatic cancer drops to close to that of someone who doesn't smoke Added risk of cervical cancer drops by about half

Source: Centers for Disease Control and Prevention.

Quitting smoking does not only benefit physical health but can also boost mental health and wellbeing: it can improve mood and help relieve stress, anxiety, and depression. Studies have shown that when people stop smoking:

- Anxiety, depression and stress levels are lower
- Quality of life and positive mood improve
- The dosage of some medicines used to treat mental health problems can be reduced

People with mental health problems are likely to feel much calmer and more positive, and have a better quality of life, after giving up smoking. Evidence suggests the beneficial effect of stopping smoking on symptoms of anxiety and depression can equal that of taking antidepressants[145].

Quitting

Smoking is not a lifestyle choice but a dependency requiring treatment. This was recognised in 2017 by the government's commitment for the NHS in England to become smoke-free[58]. Supporting smokers in contact with the healthcare system to quit is a prevention priority in the NHS Long Term Plan[31] and every health and care professional has a role to play.

Over half (52.7%) of smokers say they want to quit, and 1 in 5 intends to do so within 3 months[37]. Currently around half of all smokers in England try to quit with no help, just using willpower alone, despite this being the least effective method[146].

National guidance

Being encouraged by a healthcare professional is one of the most important motivational factors for someone who wants to quit smoking. The success of quit attempts can be significantly increased by helping patients identify and access appropriate quit aids and further support[146].

NICE guidelines

The national institute of health and care excellence (NICE) revised their guidance on Tobacco: preventing uptake, promoting quitting and treating dependence in November 2021[8]. This guidance covers areas such as preventing uptake of smoking, promoting quitting, treating nicotine dependence, and the use of e-cigarettes.

Local commissioners and providers of healthcare have a responsibility to follow the NICE guidelines. They should do so in the context of local and national priorities for funding and developing services and to have due regard to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in these guidelines should be interpreted in a way that would be inconsistent with complying with those duties. Table 1 in appendix 6 provides a full outline of all the recommendation topics introduced in the 2021 NICE guidance. This includes guidance on issues like adult-led interventions in schools, stop-smoking services, support in secondary care, adherence, and relapse prevention, identifying pregnant smokers, and incentive schemes.

NCST Guidance

The National Centre for Smoking Cessation and Trading (NCSCT) outline an array of interventions, rating each to show the extent to which it is evidence-based[147]. A description of each intervention and their evidence rating can be found in appendix 7.

The National Centre for Smoking Cessation and Trading (NCSCT) originally published guidance for local authorities that provided evidence-based, best practice guidance for both commissioners and providers of stop smoking services in 2014. This resource has been the foundation of service delivery for over a decade. At the end of March 2024, the guidance was updated and transformed reflecting the latest evidence and developments in stop smoking interventions and aids. The document provides a renewed vision for stop smoking services, principles for high-quality service delivery, and quality standards for the benchmarking of stop smoking services. The guidance stresses the importance of targeting and tailoring services to meet the needs of priority groups where rates of smoking remain high. Recognising the significant changes in the NHS prevention agenda, the guidance also provides practical support for services to remove barriers for clients moving from hospital to community.

This NCSCT guidance highlights three primary roles for Local Stop Smoking Services (LSSS):

1. To increase the number of people who make aided quit attempts, with a focus on local priority groups.
2. Provide people who smoke with access to person-centred, evidence-based stop smoking support aids.
3. Work in partnership and collaborate with other organisations across the system.

The NCSCT also provide eight evidence-based 'quality standards' which define and measure high-quality, cost-effective stop smoking services that improve quit outcomes:

- At least 5% of the estimated local population who smoke should receive a stop smoking intervention delivered by an NCSCT Certified Stop Smoking Practitioner.
- Self-reported four-week quit rates should be monitored to assess effectiveness of all forms of stop smoking support.
- Services should aim to have a four-week quit rate of at least 35%. However, services treating high numbers of people from priority groups might experience lower quit rates.
- Self-reported 12-week quit rates should be monitored and reported locally to assess effectiveness of all forms of stop smoking support.
- Carbon monoxide (CO) validated quit rates should be reported for at least 85% of in-person, face-to-face and hybrid specialist support interventions.
- All required monitoring data should be reported to NHS England (formerly NHS Digital) through the quarterly reporting and evaluation system.

- Services are evaluated and audited at least annually by service commissioners against the minimum quality standards set out within the SDMG. Quality improvement plans are implemented where standards are not being met. Ideally, services are independently audited at least every three years.
- Priority group access and outcomes should be monitored and reported locally to assess effectiveness of engagement and stop smoking interventions.

Quitting methods

Unassisted quitting

Unassisted quitting refers to an attempt to stop smoking with willpower alone, sometimes referred to as going 'cold turkey'. There is no limit on how long someone can keep trying to stop smoking.
Possible withdrawal symptoms when you stop smoking can include:

- urges to smoke or cravings
- depression
- restlessness
- poor concentration
- Irritability
- aggression
- increased appetite and weight gain

These are likely to be more severe if no stop smoking aid is used. Around 3 to 4 in 100 people remain non-smokers after a year when they choose to make an unassisted quit attempt[148].

A common way to stop smoking is by quitting abruptly on a designated quit day. Smokers who gradually reduce their smoking do not successfully quit at the same rates as those who quit abruptly. Evidence has shown that 95% of people who have a single puff on a cigarette will relapse to smoking[149]. One effective behaviour change techniques (BCT) involves commitment to the 'not-a-puff' rule, not having even a single puff on a cigarette after the quit date[150].

Cut Down to Stop programme

Individuals who feel unable to commit to stopping smoking abruptly can be supported to cut down the amount they smoke with the help of NRT, a nicotine vape or varenicline as part of a structured Cut Down to Stop (CDTS) programme. This strategy is supported by NICE[27]. CDTS is different from the harm reduction strategy of supporting reduced tobacco consumption because, with CDTS, the intention is to stop smoking completely in the near future. CDTS should be viewed as a second choice stop smoking support intervention, to be implemented when quitting in one go is not suitable, in order to extend the reach and impact of Local Stop Smoking Services (LSSS)[147].

There is strong evidence CDTS interventions are significantly more effective when they combine structured behavioural support and a first choice stop smoking aid. The use of NRT or varenicline as part of CDTS has been shown to significantly increase success and is associated with higher long-term abstinence rates, as well as reducing daily smoking[151].

NRTs that were previously licensed only for abrupt quitting have recently been granted a new licensed indication called 'cut down to stop', 'nicotine assisted reduction to stop (NARS)' or 'cut down to quit (CDTQ)'[147].

CDTS has been shown to be particularly useful in engaging people experiencing homelessness and people with SMI in stop smoking support. Therefore, staff who are working with these priority groups should be trained in supporting clients with a structured CDTS programme. CDTS is not recommended for women who are pregnant due to the significant risk of tobacco exposure to the foetus[147].

Behavioural support

Behavioural support is a term that summarises multiple components of assistance with a quit attempt. Behavioural support interventions include multi-session group therapy programs or individual counselling sessions, either in-person or by telephone or video-link.

Providing behavioural support for people using pharmacotherapy, whether in-person or via telephone has been shown to increase quit rates[152]. Table 16 shows the efficacy of behavioural support. The odds ratio indicates how many times more likely the people receiving this treatment are to stop smoking versus not receiving any treatment. Results show that people receiving group counselling are 88% more likely to achieve abstinence compared to people with no support[153].

Table 16: Efficacy of behavioural support

Type of support	Odds ratio (95% CI)
Group counselling	1.88 (1.52 - 2.33)
Individual counselling	1.57 (1.40 - 1.77)
Multi-session proactive telephone-based counselling	1.38 (1.19 - 1.61)
Text-messages	1.59 (1.09 - 2.33)
Digital apps	1.00 (0.66 - 1.52)

Source: NCSCT

Closed-group support, where the whole group starts together and had the same quit date has the highest success rate of all forms of behavioural support [153]. However, rolling groups where people join the group at different stages in their quit attempt do not have strong evidence or effectiveness.

Allen Carr's Easyway (ACE) method of stopping smoking is identified in the NICE guidance as an effective stop smoking intervention[27]. However, NICE acknowledged that the lack of evidence limited their ability to place the intervention in a hierarchy in terms of effectiveness[154]. The trials that evaluated ACE reviewed by NICE showed mixed results and had significant limitations[155,156]. In 2023, a systematic review assessed the effectiveness of ACE. Results found that the ACE seminar may be an effective intervention for smoking cessation. However, this approach deserves further randomised controlled trials with large sample sizes to strengthen the evidence base. Limited data is available on the effectiveness of reading the ACE book[157].

There is strong evidence that individual counselling is effective in supporting quitting showing that people receiving individual counselling are 57% more likely to quit[158]- shown in table 16. The evidence is greatest for multi-session support delivered by a trained stop smoking practitioner whose main role is delivering stop smoking support[159].

Telephone support has a similar effectiveness to group and individual support. People receiving multi-session proactive telephone-based counselling are 38% more likely to stop smoking- shown in table 16. Three or more calls have been shown to have a greater benefit than one or two telephone interactions. The benefit of telephone-based support in addition to intensive face-to-face support is unclear. However, telephone support may serve as a method for extending treatment between face-to-face contacts[160].

Digital support includes a wide range of support including automated text messaging, basic money saving calculator apps, personalised, interactive apps, and digital platforms with access to real-life-in-person support. Digital stop smoking interventions delivered via the use of information technology such as text messages or smartphone applications may assist with expanding the reach of LSSS among people who might not otherwise access support.

People receiving automated text message-based smoking cessation interventions result in greater quit rates than minimal smoking cessation support and have been shown to be up to 59% more likely to stop smoking[161]. However, the research to make strong recommendations concerning digital interventions is limited and there is currently no clear evidence that these are as effective as other forms of behavioural

support discussed[147]. It is important to note that this doesn't necessarily mean digital interventions are not effective, as research has indicated that these interventions can have a positive effect on smoking cessation when compared to self-help or no intervention[161–163].

Initial evaluations of the smoking cessation smartphone app 'Quit Sense' have shown possible feasibility, with modest recruitment costs and researcher time, and high trial engagement. Results showed that, when invited, as part of trial participation, to install a smoking cessation app, most participants are likely to do so, and for those using Quit Sense, an estimated one-half will engage with it for more than 1 week. Evidence that Quit Sense may increase verified abstinence at 6-month follow-up, relative to usual care, was generated, although low saliva return rates to verify smoking status contributed to considerable imprecision in the effect size estimate[164,165].

Additionally, a recent study found the use of first choice stop smoking aids alongside digital support increased effectiveness compared to digital support alone[166].

Building on this, individual, group, and telephone counselling effectiveness increases with treatment intensity (i.e. contact time)[79,167]. Increasing the amount of behavioural support is likely to increase the chance of success by about 10% to 20%[152]. The optimal amount of support – in terms of both frequency and duration – is dependent on client need as determined by their level of nicotine dependence and motivation to quit. There is evidence that some client groups require more intensive support for a longer duration. These include, but are not limited to, pregnant women and people with serious mental illness (SMI).

Repeat service users

People who smoke often need several attempts before stopping successfully. Anyone who has made a previous, unsuccessful quit attempt should therefore be offered Very Brief Advice + on how to stop smoking. As the majority of successful quit attempts are unplanned or spontaneous, people who smoke should also be enabled to stop whenever they want to[147].

Quit attempts should draw on experiences from previous attempts to stop and should bear in mind factors that contributed to previous relapses (e.g., high nicotine dependence). Groups with higher rates of smoking, such as those experiencing mental ill-health, are more likely to be repeat service users, and specific provision should be made to encourage their re-engagement with stop smoking support[147].

The evidence for relapse prevention interventions is not strong and careful consideration should be given to investing in this. There are a number of evidence-based behaviour change techniques that are supported by evidence however, in 2019 Cochrane published a review found that behavioural interventions did not provide a key benefit in helping people who had already quit with assistance (i.e., pharmacotherapies or counselling) to stay smoke free. Continued use of the medication varenicline beyond the standard treatment period did seem to help prevent relapse, though there was some variation in the results. For bupropion, the evidence was inconclusive on whether extending treatment provided a benefit, but it could not rule out a potential benefit at this stage.

For nicotine replacement therapy (like patches or gum), the evidence did not show a clear benefit of extended use in preventing relapse among those who had already quit with assistance. However, there were hints that extended nicotine replacement therapy may be beneficial for people who quit smoking without assistance[168].

Pharmacotherapy in tobacco cessation

Self-managed quitter involves over the counter smoking aids, such as nicotine replacement therapy (NRT) or e-cigarettes. Different pharmacological therapy methods may impact the effectiveness of tobacco cessation. Therefore, stop smoking aids can be categorised as first choice and second choice based on how effective they are. Appendix 7 provides further details on prescription medications for tobacco cessation.

First Choice stop smoking aids

First choice stop smoking aids are the most effective.

Nicotine replacement therapy (NRT)

While nicotine is the addictive substance in cigarettes, it is relatively harmless. NRT is a medicine that provides you with nicotine without the tar, carbon monoxide and other poisonous chemicals presented in tobacco smoke.

NRT has been widely used for many years to help people to stop smoking and is a safe form of treatment. NRT can be bought in pharmacies and other outlets or is available on prescription. NRT is available as skin patches, chewing gum, inhalers, oral strips and lozenges, and nasal and mouth sprays.

Possible side effects of NRT can include:

- skin irritation when using patches
- irritation of nose, throat or eyes when using a nasal spray
- difficulty sleeping (insomnia), sometimes with vivid dreams
- an upset stomach
- dizziness
- headaches

It has been established that providing nicotine can minimise nicotine and tobacco withdrawal symptoms as well as smokers' desire to smoke in the days and weeks after quitting[169]. NRT can increase the chance of stopping smoking for 6 months or more by more than half[77]. To further increase the chance of quitting successfully, patients can use a combination of NRT products. NRT should be used for at least 8 to 12 weeks. The dosage can be gradually reduced and eventually stop.

NRT has gained widespread acceptance as a technique for helping smokers stop. Several clinical recommendations suggest utilising NRT as the first treatment choice for smokers seeking pharmacological assistance. Depending on the country, NRT is either marketed as a transdermal patch or as a buccal absorption device (gum, lozenge, nasal spray, inhaler, or sublingual pill)[169]. In the UK, combination NRT (use of a nicotine patch plus a faster-acting NRT product) has been identified as a first choice stop smoking aid[147]. However, there is strong evidence that single-form NRT is less effective than combination NRT. There is no evidence of significant differences in effectiveness between the different types of NRT product (patch, gum, lozenge, inhalator, etc.)[170]. The evidence base for popular stop smoking products can be found in appendix 7.

Vape/e-cigarette as a stop smoking aid

E-cigarettes/vapes are the most popular stop smoking aid in England[171], and are classified as a first choice stop smoking aid.

In January 2024 a systematic literature review examining the safety, tolerability and effectiveness of using electronic cigarettes to help people who smoke tobacco achieve long-term smoking abstinence, in comparison to non-nicotine electronic cigarettes, other smoking cessation treatments and no treatment[172]. Results found that there is high certainty that nicotine electronic cigarettes increase quit rates compared to nicotine replacement therapy (NRT). In absolute terms, this might translate to an additional four quitters per 100. Research also presents a good indication that the rate of occurrence of adverse events is similar between groups. Serious adverse events were rare, and there is insufficient evidence to determine whether rates differ between groups due to very serious imprecision[172].

Additionally, research found it is likely that nicotine e-cigarettes increase quit rates compared to non-nicotine e-cigarettes. In absolute terms, this might lead to an additional three quitters per 100. The research also showed that it is likely there are no difference in the rate of adverse events between these groups. There is insufficient evidence to determine whether rates of serious adverse events differ between groups[172].

Due to issues with risk of bias, there is limited quality in evidence that, compared to behavioural support only/no support, quit rates may be higher for participants randomized to nicotine e-cigarettes. In absolute terms, this represents an additional four quitters per 100. There was some evidence that (non-serious) adverse events (AEs) may be more common in people randomised to nicotine e-cigarettes and, again, insufficient evidence to determine whether rates of serious adverse events (SAEs) differed between groups[172].

From this study the following implications for e-cigarette research were made[172]:

- Further randomised controlled trials of nicotine e-cigarettes are needed, with follow-up periods of 6 months or over.
- Active comparator trials and trials testing e-cigarettes combined with other medication would be useful for decision makers.
- Studies should use updated e-cigarette devices with good nicotine delivery.
- Further high quality reviews are needed on the relationships between e-cigarette availability/use and youth cigarette/e-cigarette uptake, as well as the safety of e-cigarettes in never smokers.

There is a positive perception of the assistance vaping provides in stop smoking services within the young adult population. In the ITC Youth Tobacco and Vaping Survey[5] over half of 16 to 19 year olds perceived that vaping makes quitting smoking permanently 'a bit' or 'a lot easier' (60%). Many (14.2%) thought it had 'no effect,' just under one-tenth (9.6%) perceived that vaping made quitting 'a bit' or 'a lot harder,' with 15.9% saying that they did not know.

Overall, the role that e-cigarettes/vaping can play as the most effective aid in helping adult smokers to quit is acknowledged. This strength of evidence has led to the provision of free vape kits for 1 million smokers over the next two years to help them "swap to stop"[25]. The potential for this is clear as although adult vaping continues to grow year on year mainly among ex-smokers to prevent relapse or current smokers trying to cutdown or quit, more than one in four (27%) of adult smokers have never tried vaping.

Utilisation of stop smoking services

Reducing smoking rates is the single biggest thing that can be done to improve the nation's health. It will reduce cardiovascular disease, respiratory conditions and cancer, meaning people can live longer in better health and, according to the Royal College of Physicians (RCGP), it will save the NHS up to £890 million a year[101].

As shown above, there is clear evidence that the most effective way to quit smoking is with expert behavioural support from local stop smoking services combined with stop smoking aids[47]. Prompts by healthcare professionals are the second most common reason for someone to make a quit attempt. However, there has been a fall in the utilisation of stop smoking services within healthcare settings.
In 2019, Public Health England (PHE) released guidance titled "Health matters: stopping smoking – what works?". The guidance highlighted the percentage of quit attempts initiated in healthcare settings in England between 2009/10 and 2017/18. Results showed a fall in the number of quit attempts in primary care settings from around 45.0% in 2009/10 to below 40% in 2017/18[173].

Similarly, the guidance also presented the percentage of all those who smoked in the past year who reported a GP triggered quit attempt that year (3-month averages), in England, between June 2009 and June 2018. Findings showed that GP triggered quit attempts are also falling from just under 9.0% in 2009 to just under 6.0% in 2018[173].

This decrease in utilisation could indicate that services are no longer effectively reaching the smoker population[174]. Research has identified several explanations including:

- a lack of mandatory identification of tobacco users across primary, secondary and community healthcare settings[175].
- the pressure of service targets for the number of four week quitters[176].

- Limited support, guidance, and policy for disadvantaged populations (such as those within mental health or criminal justice settings)[177,178].

Effective referral routes from both primary and secondary healthcare are important to ensure that all smokers who need it get this specialist support. GPs are normally the first point of contact for patients. Table 17 highlights the actions healthcare professionals should take to support the utilisation of stop smoking services.

Table 17: A call to action to increase utilisation of stop smoking services across healthcare professions

Healthcare Profession	Call to action
Pharmacy teams	Pharmacy teams have a variety of opportunities to discuss smoking, such as when people are buying NRT, purchasing cough medicines repeatedly, or when dispensing medicines for smoking-related conditions such as high blood pressure, COPD, diabetes, and heart disease. Smokers interested in quitting may also ask about e-cigarettes, so pharmacy staff should update their knowledge on the evidence and products available, by completing the NCSCT online training module.
Primary care	GPs should advise patients who smoke that the most effective way to quit smoking is a combination of behavioural and pharmacological support. Stop smoking aids (NRT, Champix* and Zyban) can be prescribed for smokers who want to quit. While e-cigarettes are not currently available on prescription, GPs should provide advice to patients who are interested and may find them beneficial, in line with NICE guidance.
Secondary care	It is estimated that 1 in 4 patients in acute hospital beds in England are smokers and this presents a unique opportunity to offer stop smoking advice. Achieving the ambition of a truly smokefree NHS means: • every front-line healthcare professionals discusses smoking with their patients • all smokers are offered on-site stop smoking support or referral to local services • hospital buildings and grounds are completely smokefree
Mental health services	All frontline clinicians should ensure that tobacco dependency is treated among people with mental health problems as part of their clinical care. This includes the provision of a full range of stop smoking support, whether a patient wants to quit for good or temporarily abstain while in a smokefree NHS setting. Tobacco dependence treatment pathways between secondary and primary care are essential to reduce the inequalities gap and ensure continuity of care.
Maternity services	NICE guidance recommends that all pregnant women should be screened for carbon monoxide (CO), with those having elevated levels referred for specialist stop smoking support. Members of the midwifery team should be trained in the use of the CO monitor and in having a brief meaningful conversation about the harms of smoking and the support available. Robust and effective pathways into specialist support should be in place, with feedback to the referring midwife.
Local authorities	Local authorities should continue to identify local need using the fingertips tool and provide stop smoking services, particularly for priority populations and those in greatest need. Local authorities should continue to promote the NHS Health Check which presents an ideal opportunity to offer advice on quitting smoking. All smokers should be offered a referral to their local stop smoking service. Research published in the BMJ has shown that people who attend an NHS Health Check are twice as likely to be referred to smoking cessation clinics[179].
Local stop smoking services	Local stop smoking services should engage actively with smokers who want to use an e-cigarette to help them quit and provide the additional support that will give them the best chance of success.

*Varenicline (brand name Champix) is not currently available. It has been withdrawn as a precaution because of an impurity found in the medicine. It is not yet known whether it will be available again in future.
Source: GOV.UK

Smoking cessation

Smoking cessation service models

Table 18 provides an overview of Local Stop Smoking Services (LSSS) commissioning models.

Table 18: An overview of LSSS commissioning models

Commissioning Model	Pros	Cons
Centralised, specialist A single service that delivers a range across the region.	• Coordinated approach • Greater assurance around consistency of quality	• Lack of specialised knowledge to reach all priority groups effectively • Limited capacity to expand or reach some priority groups
Hub and Spoke A central service provider (the Hub) is funded to deliver the support. They then subcontract other providers such as primary care, community pharmacies and third sector organisations to deliver all or some of the support. The hub will retain delivery of areas such as admin training, specialist intensive support and marketing resources.	• Responsive to changes in demand and need • Able to employ specialist knowledge and skills where needed • Single point of access • Accommodates innovation. Can evolve and innovate quickly	• Relies heavily on Hub's operational efficiency and leadership • Potential dilution of quality by subcontracted providers who are not specialists
Decentralised Support is individually commissioned, with each support option funded separately. Each support model may be delivered by a different provider.	• Rapid response to target groups	• Uncoordinated approach, leading to gaps in service • Possible loss of oversight • Unable to respond and move resources to meet change in demand • Multiple points of access may be confusing to users

Source: NCSCT

Smoking cessation delivery models

LSSS were built around the principle of a universal offer support that combined pharmacotherapy with behavioural support. Six contacts with weekly support for the first four weeks after setting a quit date is based on the NCSCT Standard Treatment Programme (STP). This universal model results in at least three times greater success with quitting when compared to no support[159].

To maximise reach and efficacy of LSSS, commissioners may need to provide an array of service delivery models. Table 19 provides a summary description of interventions ranked in a hierarchy of effectiveness. The table describes the efficacy and reach of service delivery models, and considerations for commissioners. Further detail on each service deliver model can be found from page 115 of The NCSCT guidance: commissioning delivery and monitoring guidance.

The evidence rating is based upon an adapted version of the Scottish Intercollegiate Guidelines Network (SIGN) rating system, an internationally-recognised scale used to rate research evidence[2]. These ratings are as follows:

- A: The intervention is supported by strong evidence
- B: The intervention is supported by reasonable evidence but there may be minimal inconsistency or uncertainty
- C: The intervention is supported by expert opinion only

- I: There is insufficient evidence
- ✓: Good practice point (in the opinion of the guidance development group

Table 19: Stop smoking interventions ranked based on evidence of effectiveness

Rank	Service delivery model	Description	Evidence grading	Efficacy (increase in quit rate)	Considerations
1	**Standard Treatment Programme**	Minimum six contacts (weekly or bi-weekly) delivered over 6 to 12 weeks, in person or via telephone or video link, from a trained stop smoking practitioner.	A	300%	Will provide the best quality outcomes for majority of people who smoke. Should always be the first option considered for commissioning stop smoking interventions. The frequency of contact may not appeal to all service users and/or be possible in existing budgets for all clients.
1	**Group-based Standard Treatment Programme**	Weekly or bi-weekly contacts delivered over 6 to 12 weeks in a closed group format by a trained stop smoking practitioner.	A	300%	While effective, coordination of groups can pose logistic challenges for services.
1	**Tailored specialists stop smoking programme**	Weekly or bi-weekly support delivered over 12 to 26 weeks by a trained specialist stop smoking practitioner.	A-B	200-300%	Most appropriate for people with an SMI, pregnant women and individuals at high risk of relapse.
2	**Brief support and treatment programme**	Initial session with follow-up contacts at approximately two and four weeks, delivered by either a trained specialist stop smoking practitioner or trained community health or social professional (e.g. pharmacist, GP, nurse, social care worker) alongside the provision of a first choice stop smoking aid.	B	50-100%	Can be commissioned via GP surgeries, pharmacies or delivered by the LSSS.
2	**Hybrid models**	Combine digital and interpersonal support alongside the provision of a stop smoking aid	B-C	-	Can assist with reducing number of interpersonal contacts.
3	**Cut Down to Stop programme**	6 to 12 contacts delivered to clients who will initially cut down on smoking	B	40-80%	Most appropriate for people who will benefit from a longer lead in time, in particular priority groups (e.g. people experiencing

		before stopping completely, along with provision of a first choice stop smoking aid.			homelessness, people with an SMI)
4	**Digital support programme**	Advice, tips and information and remote support from a stop smoking app and/or text messages alongside the provision of a stop smoking aid.	B-C	40– 80%	Digital support alongside pharmacotherapy has less of an evidence base but may be a good option for people who would otherwise not access services.
5	**Self-help and stop smoking aid following brief advice**	Brief advice and self-help alongside the provision of a stop smoking aid	A	20-80%	Appropriate for clients who are unable to engage in more intensive models.

Source: NCSCT

Very brief advice

Very Brief Advice on Smoking (VBA) is a lifesaving intervention which triggers quit attempts. This approach meets the Making Every Contact Count (MECC) agenda[180]. It needs to be delivered opportunistically and repeatedly at every opportunity with people who smoke. It was originally designed to be delivered by general practitioners and involve referral to specialist stop smoking services. VBA is recommended by NICE as evidence-based and cost effective.

There are three elements to VBA:

- Establish a record smoking status (ASK)
- Advise on how to stop smoking (ADVISE)
- Refer to specialist stop smoking service support (ACT)

Based upon an adapted version of the Scottish Intercollegiate Guidelines Network (SIGN) rating system, an internationally-recognised scale used to rate research evidence[181]. VBA evidence rating is A (supported by strong evidence)

To reflect this widespread adoption of VBA, and the changing access to stop smoking support, the original model was updated in 2021 to VBA+ (new evidence rating of B [supported by reasonable evidence but may be minimal inconsistency or uncertainty]). The principles (ask, advise, act) remains the same. The updated VBA+ model includes advice on tailoring the referral intervention to improve uptake and engagement with stop smoking services. To inform the ACT component of VBA+ identification of available LSSS is necessary to allow for effective referrals.

Referral source and pathways

Only a small fraction of quit attempts are made with the most effective method of quitting: a combination of stop smoking aids and behavioural support from a trained practitioner. For effective referral of all clients, and notably those in priority groups, it is important to ensure seamless pathways are established and integrated with various local health and social care networks.

The NCSCT provide six principles for maximising effective referrals[147]:

- Have a visible presence in the community and ensure that this presence is regularly reviewed and refreshed.
- Implement a targeted outreach programme for priority groups.
- Co-design referral pathways with people who smoke and ensure that they are person-centred.

- Set minimum response times and quality standards for responding to referrals.
- Ensure staff receive training in VBA+ that is ideally tailored to their setting and complete refresher training periodically.
- Develop simple electronic referral systems that support the principles for effective referrals and allow for analysis and reporting to commissioners and referrers.

The NCSCT also provide 3 examples of best practice:

- Stop Smoking London
- Fresh and Balance (North East of England)
- Breathe (Camden)

Self-referral

Self-referrals are the primary referral pathway. Best practices include[147]:

- A single point of access to all support services with a dedicated helpline, as well as digital access. Information should be shared across social media.
- The provision of information in the most prevalent non-English languages locally and in British Sign Language (BSL). Some (mainly older) non-English speakers do not read or write their first language, so images and key words only may be relevant. Engaging with the local community to understand their needs and co-produce appropriate resources is vital.
- Co-designing services with people who smoke and with service users to actively identify and remove barriers to access[182].
- Supply of posters, leaflets and cards for healthcare professionals to hand out and display to promote and maintain the profile of LSSS.
- Information on website should help individuals make informed decisions and encourage individuals into the most effective and appropriate support.
- All communications and referral processes should be person-centred and tailored to the local community. This includes using language that will resonate and engage members of priority groups.

Primary care

Staff in general practice and primary care teams have regular contact with large numbers of people who smoke, and they are a key setting for delivery of VBA+ and for generating referrals to LSSS.
The number of quit attempts triggered by GPs has declined in the last decade[129].Good working relationships with primary care providers are important for improving training in VBA+ and increasing rates of referrals by identifying and removing barriers. Multi-component interventions to address barriers and increase uptake of VBA+ in primary care are most effective[183–185]. Best practice includes:

- GP surgery pathways should be developed, with named responsibility for delivering each element of VBA+.
- Training primary care providers increases delivery of VBA+ and results in more patient referrals.
- Primary care staff should have the skills to deliver VBA+ and to provide accurate information to patients on the benefits of smoking cessation and the value of stop smoking aids and support[129,182,186]. Refresher training and performance coaching increases rates of delivery[183].
- Having a smoking cessation champion within each primary care setting can significantly improve rates of VBA+ delivery and rates of referral to LSSS[184,185,187].
- Automated medical record prompts and simple electronic referral tools can increase delivery of VBA+[188–190].
- Offering Carbon monoxide monitoring alongside VBA+ and facilitating access to free or low-cost stop smoking aids can increase patient motivation to quit[188].
- There is some limited evidence that proactive outreach to patients identified as people who smoke in clinic medical records can serve to increase uptake[188].

Community pharmacy

Community pharmacies are frequently people's first point of contact with health services. They play a key healthcare role in many areas of higher deprivation where there are greater numbers of people who smoke. Healthy Living Pharmacies are taking a bigger role in supporting the health of local communities. Working

with local community pharmacies to encourage and support delivery of VBA+ can serve to prompt quit attempts. Community pharmacy champions and electronic referral to LSSS may serve to enhance referral rates[147].

A number of community pharmacies provide smoking cessation support, enabling them to identify and support clients in-house. Community pharmacies may also play an independent CO monitoring role to support remote delivery of support[147].

Evidence of good practice in local stop smoking services

Local councils play a pivotal role, supporting and promoting stop smoking services by implementing a combination of policies, education, and support programs. Tackling smoking requires a comprehensive and collaborative effort, and through these initiatives, councils can contribute significantly to building healthier, smoke-free communities. By addressing smoking at the grassroots level, councils create a ripple effect that benefits both current and future generations[191]. Table 20 summarises existing good practice in local stop smoking services across the UK identified by the Local Government Association (LGA).

Table 20: Evidence of good practice in local stop smoking services across the UK

Place: **Intervention**	Description

Newham: **Targeting manual workers and people with long-term conditions**	• Newham's stop smoking service Quit Well Newham established several priority groups for targeting its support- including manual workers alongside people with long-term conditions.
	• It provides quit aids such as NRT and e-cigarettes alongside expert support from a stop smoking adviser. The adviser offers four weekly sessions as standard- this can be extended up to 12 weeks for priority group clients. These sessions are held either face-to-face, on the telephone, or via video link.
	• The service has started doing some outreach by going out to work locations. Over the past year this has included visits to construction sites, the local Tate and Lyle sugar factory and the council's depot where refuse workers and other teams work.
	  ○ Due to the targeted outreach, smoking prevalence among adults in routine and manual occupations has now dropped to 9.9 per cent in Newham, which is below the London and England averages.
	• Work with people with long-term conditions has involved close partnership with the NHS. The local trust- Barts Health- has its own stop smoking adviser who works with people when they are admitted to hospital. Patients are then referred directly on to the Quit Well Newham team when they are discharged.
	• Referral pathways have also been established with primary care teams, including GPs, who routinely offer smokers referral to Quit Well Newham when smoking status is recorded.
	• A similar arrangement is in place with East London Foundation Trust, which provides inpatient mental health support. Their stop smoking adviser starts support before referring on to the Quit Well Newham team.
	• The team has also started targeting its work towards the most deprived areas in the borough. This has involved holding outreach clinics in community locations such as libraries and a local GP surgery.
	  ○ Figures show those that receive support have a very good chance of quitting. More than 2,000 people have been helped by the service since it was launched with 54 per cent achieving quit status by the end.

Buckinghamshire: **Creating smokefree sidelines and parks**	• In Buckinghamshire, the council's public health team has worked with the local football association to prevent smoking and vaping at youth football matches as well as introducing a similar initiative targeted at local parks and playgrounds. • The campaign encourages local football clubs to not allow smoking or vaping at youth matches. The idea is to encourage smokers to refrain from smoking and vaping during the match. • So far 14 clubs have signed up to the scheme with talks ongoing with another three. • A range of different assets are offered to those clubs taking part including posters, car stickers and banners with the tagline "We copy what we see, let's make our sport

	smokefree". There is also the option to order bespoke items, such as tabards and feather flags. And, the local stop smoking service, Be Healthy Bucks, is signposted to help those who want to stop smoking. • Presentations on Smokefree Sidelines was provided to clubs and the initiative is promoted at tournaments and open days. A podcast has also been published. • Alongside Smokefree Sidelines, Buckinghamshire has also launched a similar project focussed on playgrounds and parks. The council has focussed on the Opportunity Bucks areas, which are the 10 most deprived parts of the county. Again, the idea has been to target the work in a way that captures communities where smoking is most prevalent. • Advanced Public Health Practitioners work with the community boards and parish councils to identify the parks and playgrounds and then we approach the local schools to run a competition to design the signage for the parks and playgrounds. • Buckinghamshire is now looking to build on the work that has been done by cracking down on illegal sales. To do this, the public health team has started funding a trading standards officer to focus on underage sales of tobacco as well as alcohol and vaping in a two-year pilot.

Southampton: **Embedding stop smoking expertise across services**	• Residents in Southampton who want to quit smoking and need help can access national NHS materials and an eight-week package of help via many pharmacies or their GP practice if they need it. In line with national guidance, these locally commissioned services provide specialist support and nicotine replacement therapy.
	• However, the public health team recognise this will not reach some important groups. Therefore, alongside a basic universal offer, specialist stop smoking support and expertise is being embedded in services such as hostels for people who are homeless, drug and alcohol support, maternity care, and mental health services.
	• Solutions 4 Health was commissioned to manage and run Southampton Smokefree Solutions (SSS). SSS has a training, development, and quality assurance role, building capacity across the health and care system.
	• Over the last three years SSS has done this in a variety of ways. Like many areas, SSS has run very brief advice training for frontline staff to help them engage the people they work with about their smoking. More than 150 people have completed this training.
	• But alongside this, the service has also delivered stop smoking support in these settings and trained staff to become stop smoking specialists, so they can provide the treatment longer term.
	  ○ One project has involved working with the Salvation Army, which runs a homeless hostel service in the city. The SSS team attend breakfast clubs to engage with clients and deliver tobacco dependency treatment.
	  ○ The work with the drug and alcohol service has been slightly different. Southampton City Council commission Change Grow Live (CGL) to deliver drug and alcohol treatment services. The SSS team began by delivering treatment within the service and collaborating with CGL such that the provider is now deliver tobacco dependency treatment themselves.
	  ○ Similar arrangements have been introduced with the local mental health trust as well as with primary care staff. Through working with the six local primary care networks, SSS has helped train a variety of staff from social prescribers, practice nurses and in-house pharmacists to becomes stop smoking specialists.
	• To support the frontline staff who have become stop smoking specialists, SSS run a monthly practitioner network to share best practice, provide updates and facilitate peer support. Some 140 practitioners are part of the network and have been trained or supported by SSS, including pharmacists, occupational health advisors and midwives. Many of the practitioners are part of services which have received funding from public health.
	• NHS Digital figures for 2022-23 show more than 6,000 smokers per 100,000 set a quit date in Southampton through stop smoking services – more than double the national

	rate, the self-reported quit rate in Southampton was also more than 50 per cent higher than England.

Oxfordshire: **De-normalising smoking through partnership work**	• Oxfordshire County Council has set up an alliance of partners to help develop initiatives to nudge local people into not smoking. Projects have included stopping smoking at playparks and school gates as well as a smokefree event to celebrate the King's coronation. A community fund is available to support the work, which complements the help provided by the local stop smoking service for residents to quit.
	• The Tobacco Control Alliance has more than 50 partners, including the district and city councils, local NHS trusts and voluntary sector. It meets three times a year to share good practice and support delivery of the county's Tobacco Control Strategy. The community fund, with grants of up to £1,000 at a time, is available for partners who want to run smokefree events and initiatives.
	• The partnership work has led to a wide range of initiatives – with the fund used to help pay for equipment and signage where needed. For example, Witney Town Council was given money to pay for new signs around playgrounds encouraging people not to smoke. Local children even took part in a competition to design the signs.
	• Witney Town Council Leader Councillor Dr Ruth Smith said the district was motivated to act after local polling showed that 90 per cent of Oxfordshire smokers themselves agreed that creating smokefree parks was a good idea.
	  ○ The local football association has also encouraged spectators not to smoke at football matches – and now efforts are being made to get the local rugby and rowing associations to follow suit.
	  ○ Turning Point, which run the drug and alcohol Roads to Recovery service, has also got involved. Their advisers are trained to offer support, but the fund has been used to supply them with vapes to help their clients to quit smoking.
	  ○ Response, which manages sheltered housing for mental health patients, has made its accommodation smokefree and was given money to buy ballot bins for cigarette butts. These allow smokers to vote on a question on the side of the bin by putting the butts in one side or another.
	  ○ Smaller community groups have also made use of the fund. For example, the local residents' association in Barton applied for funding for some Smokefree signage for an event held for the King's coronation.
	  ○ Oxfordshire has also encouraged local schools to create smokefree school gates by asking parents not to light up when picking their children up.

North East Lincolnshire: **Equipping children with the skills to say no**	• Thousands of secondary school pupils in North East Lincolnshire are receiving support and education to encourage them not to take up smoking. The council has used a world-leading programme called INTENT to deliver the smoking prevention work. • The INTENT programme was developed by team of psychologists at the University of Leeds and its use is now being supported by the social enterprise Evidence to Impact. • It involves delivering two lessons a year to pupils from years seven to 10. During the lessons pupils are provided with information about smoking, covering everything from its impact on health to the financial cost of it. • It works out at less than £1 per pupil and is due to run for four years. It is based on a train-the-trainer model with the INTENT team providing training to members of the council's public health team, including school nursing. Teachers have then been trained to deliver the programme.

	○ As part of the lessons, pupils think about what they would say if they were offered a cigarette in a series of "if this happens … then I will do this." The scenarios are created to help develop the resilience to deal with pressure from friends or associates to smoke. Now in its second year vaping has been incorporated into the lessons too. • According to research, 25.6 per cent of the students that received INTENT are less likely to report having ever smoked than those that did not participate in the programme. • The council has got 10 schools signed up to the programme, including all the secondary academies, as well as the local pupil referral units, meaning more than 8,000 pupils are being reached. • In total training has been provided to all teachers providing PSHE lessons and some PE staff. The schools receive access to all lesson plans, interactive white board resources, guidance, and support to help them deliver the education sessions.

Source: LGA

Additionally, recent research conducted by the University of East Anglia (UEA) has also shown that giving out free e-cigarette starter packs to smokers in hospital accident and emergency (A&E) departments may help support more people to quit smoking. The Cessation of Smoking Trial in the Emergency Department (COSTED) was carried out at six UK hospitals, including the Norfolk & Norwich University Hospital. Participants were randomly assigned to receive either brief advice, an e-cigarette starter kit, and stop smoking service referral, or no intervention (control group). Participants were generally from deprived neighbourhoods, with a higher-than-average number unemployed or unable to work due to sickness or disability[192].

Out of 972 participants, 1 in 4 in the intervention group reported quitting smoking at 6 months, compared to 1 in 8 in the control group. Carbon monoxide tests confirmed that those in the intervention group were twice as likely to quit. They were also more likely to reduce how many cigarettes they smoked and to make more attempts to quit than the control group[192].

The trial demonstrated the potential of emergency departments to reach smokers opportunistically, especially in disadvantaged communities. Economic evaluation suggested the intervention is cost-effective and implementing it across the three Accident and Emergency departments in Norfolk could lead to 1,636 additional quits annually at a lower cost than traditional methods[192].

In January 2024, Norfolk County Council published their Smoking and Tobacco Control Health Needs Assessment. The assessment highlights the current work supporting inpatients to stop smoking at James Paget University Hospital.

> "In Norfolk and Waveney, this started in May 2022, with support being offered directly in hospitals. The James Paget University Hospital in Great Yarmouth was chosen early because many people in the area smoke, and there are greater health inequalities in that area than in other areas of Norfolk. When hospital patients are identified as smokers, they are referred to a specialist team to help them quit. The team provides nicotine replacement therapy (NRT) and other support to increase the patient's chances of quitting. When leaving hospital, patients receive extra NRT and are referred to Smokefree Norfolk for further support at home.
>
> Since the project started, 87% of smokers have been referred to the team, with 79% receiving support and 24% successfully quitting smoking. These results are encouraging, especially as people may not have been planning to quit before they went into hospital."

Furthermore, the Norfolk JSNA also discusses the success of a pilot programme run in 2020 and early 2021, offering vouchers for vape starter kits or refills to specific groups in Great Yarmouth. Norfolk County Council Public Health, Smokefree Norfolk and the University of East Anglia conducted this programme in areas

identified as having the highest smoking rates in Norfolk, targeting groups of individuals who had unsuccessfully tried to quit smoking, those with multiple health conditions, and people with mental health conditions.

During the trial, over 340 participants used their vouchers, and many provided positive feedback. Encouragingly, 42% of those who switched to vaping quit smoking at 4 weeks, with vapes proving effective where other methods had failed. The trial also helped dispel the myth that vaping is as harmful as or more harmful than smoking.

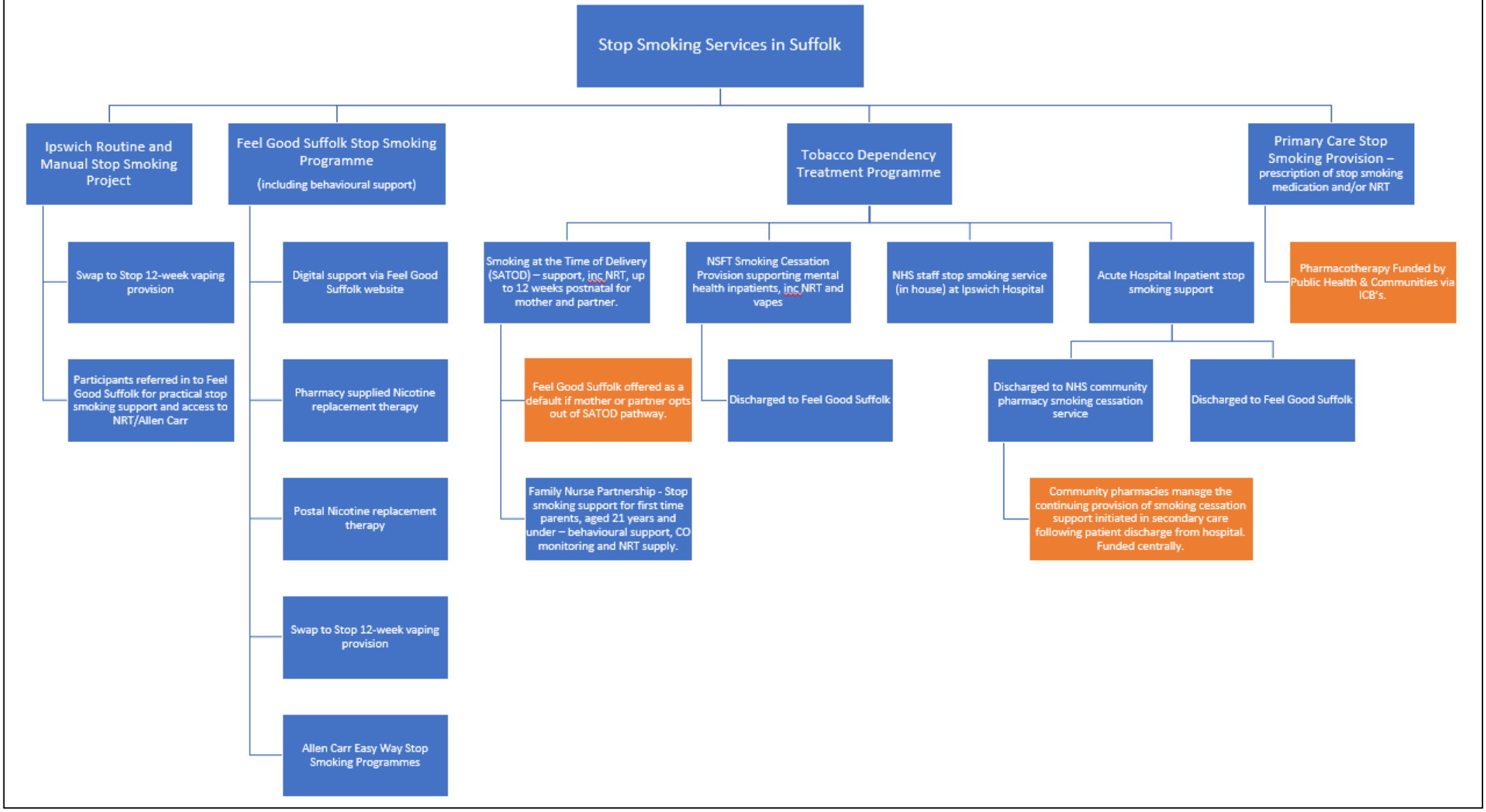
Given the success of the vape voucher trial, the service was expanded countywide in 2022, offering free 12-week vape vouchers to everyone in Norfolk as part of the stop smoking service. Recent figures show a 52% smoking quit rate at 4 weeks, surpassing the initial target.

Local service mapping

Figure 32 shows a breakdown of the stop smoking services currently being provided within Suffolk. There are 4 main branches of stop smoking services:

- Feel Good Suffolk Stop Smoking Programme
- Projects supporting specific population groups (such as the Ipswich Routine & Manual Stop Smoking project)
- The Tobacco Dependency Treatment Programme delivered within NHS secondary care
- Primary Care Stop Smoking Provision

Figure 32: Stop Smoking Services in Suffolk, 2024



Feel Good Suffolk

Feel Good Suffolk provides Suffolk's smoking cessation service- the site also mentions paan, bidi and shisha support. The service started in 2023 and is a partnership of local councils and health colleagues, building on their close links with communities to offer greater choice and flexibility of services to meet the needs of residents. People can self-refer, refer on behalf of someone else, or be referred by a professional.
Feel Good Suffolk primarily offers three methods of smoking cessation:

1. **1-to-1 behavioural support and Nicotine Replacement Therapy (NRT)**
   Feel Good Suffolk Advisers deliver 1-to-1 behavioural support and facilitate the order of subsequent NRT for collection by the client from one of 43 pharmacies that have signed up to the new Nicotine Replacement Therapy dispensing contract (as of January 2024). NRT is also available by post[193].
2. **Allen Carr's easy way to stop smoking programme**
   Feel Good Suffolk can refer individuals to online webinars and face to face seminars are offered through Allen Carr. Seminar locations include Felixstowe, Lowestoft, Haverhill, Stowmarket, and Sudbury. In the first four months of the Feel Good Suffolk service (October 2023 to 14 January 2024), 113 people were referred to the service[193].
3. **"Swap to Stop" vape offer**
   Feel Good Suffolk are able to provide vape starter kits and limited behavioural support to adults (18 and over) wishing to quit on a 12-week programme. Training has been arranged with preferred vape suppliers, and a webpage is currently being created to provide behavioural support, troubleshooting advice, and instructions on how to order future vape supplies for clients where required[193].

In the first four months of the Feel Good Suffolk service (October 2023 to 14 January 2024), 697 referrals (26.3%) were for smoking cessation[193].

Supporting specific population groups

Residents in Suffolk who want to quit smoking and need help can access national NHS materials and the Feel Good Suffolk smoking cessation service. In line with national guidance, these locally commissioned services provide specialist support and nicotine replacement therapy. However, the public health team recognise this will not reach some important groups. Therefore, alongside a basic universal offer, specialist stop smoking support and expertise is being embedded to support specific population groups. These projects are outlined below.

Ipswich Routine & Manual Stop Smoking project

The Ipswich Routine and Manual Stop Smoking project is a one year (2023-24) project funded by SNEE ICS and managed by Suffolk County Councils Public Health and Communities directorate. The aim of this project is to engage with smokers who are routine and manual workers (including their friends, family, community, and colleagues) who work and may live in Ipswich. They are offered Very Brief Advice, 12-week vape starter kits, NRT or a referral into Allen Carr Easy Way to stop smoking and onward support offered by Feel Good Suffolk.

Lowestoft healthy hearts project

The Lowestoft healthy hearts project is a project scheduled to run for 2 years (2023-25). It aims to address health inequalities in Lowestoft with a focus on cardiovascular disease (CVD), including hypertension and underlying risk factors such as smoking. The project will centre on the wards of Harbour & Normanston and Kirkley and Pakefield.

Family Nurse Partnership for young parents

The Family Nurse Partnership programme is a free and voluntary service for under 20s who are expecting their first baby and registered with a Suffolk GP. It is delivered by East Coast Community Healthcare in Waveney, and a team within Suffolk County Council's children's services directorate covers the rest of Suffolk. Support covers many topics including "addressing health needs such as stopping smoking."

MyHealth drop-in service

MyHealth drop-in service is provided by the Norfolk and Suffolk Foundation Trust (NSFT) Adult Learning Disability Team. The team work with people with learning difficulties and people with autism, carrying out physical observations such as blood pressure, weight, heart rate, blood glucose levels, and signpost into other services for help stopping smoking or with weight management[194].

Fishermen & families

Approximately 30% of seafarers smoke tobacco, though others have reported up to 63.1% according to the Seafarers' Hospital Society[195]. Fishwell services providing mental health and wellbeing support to fishermen and their families in Lowestoft, Southwold, Dunwich, Sizewell, Thorpeness, Aldeburgh, Felixstowe, Orford. Services include Seafit, which offers free health checks, and advice on stopping smoking, alcohol reduction and weight management.

Smoke Free Homes

Across Suffolk a Smoke Free Homes policy was launched in 2022. Tenancy Agreements were adapted to include a statement regarding a commitment to smoke Free Homes and to encourage tenants to cease smoking within properties- this was not enforceable. Policies in relation to letting newly developed properties (built, developed, and owned by Flagship) were also adapted and are now all advertised as smoke free homes.

Today Suffolk County Council continues to promote smoke free homes on social media and reference nation stop smoking days. Smoke free homes are now cemented into the new tenancy process and work with tenants in their homes when they have been identified as a smoking household (for instance if the home smells of tobacco or there is noticeable tobacco usage). Aims to further refresh approaches with staff are underway.

The Selig Suffolk Trust

The Selig Suffolk Trust offers support (including for smoking cessation) to people who are homeless and staying at Selig Suffolk Trust accommodation (up to seven short-term supported places, and ten tenants in supported homes). In 2019/20, when Selig ran the Ipswich winter night shelter, most clients were smokers. Selig worked with One Life Suffolk, who offered health checks and stop smoking support. From this a total of 12 people were helped to quit.

Today, vaping kits are provided if needed; however, it has been reported that less than 50% of clients are smokers, with most already utilising vapes for smoking cessation.

ChatHealth Texting Service

ChatHealth Texting Service enables children and young people to receive general health advice (which might include smoking) from a school nurse. Feel Good Suffolk offers stop smoking support to children and young people aged 12 and over. Work is underway to embed age-appropriate lessons on healthy behaviours and mental resilience in personal, social, health and economic education (PHSE), and to develop targeted social media campaigns.

NHS secondary care: tobacco dependence treatment

The NHS Long Term Plan (LTP) has set out a commitment for the NHS to deliver NHS funded tobacco dependence treatment (TDT) services across inpatient, maternity and outpatient/community settings (for example ESNEFT TDT, James Paget smoking cessation service).

As part of the TDT service, acute hospital inpatients are discharged to the NHS community pharmacy smoking cessation service or to Feel Good Suffolk.

Suffolk and North East Essex ICB

Suffolk and North East Essex (SNEE) ICB (including West Suffolk Hospital and Ipswich Hospital) has committed to having the NHS Plan Tobacco Dependency Treatment programme in place by 2024/25. The pathway includes an integrated discharge to local community services provided by Local Authority, smoking cessation providers and pharmacy. In January 2024, "key challenges relating to recruitment, data submission and monitoring of pharmacotherapy use/costs are being addressed"[196].

East Suffolk and North Essex NHS Foundation Trust (ESNEFT)

ESNEFT provides services from Colchester and Ipswich hospitals, five community hospitals and Bluebird Lodge (Ipswich), as well as community services in Suffolk and north Essex. Between November 2022 and October 2023, 280 smokers were identified in acute inpatient (n=260) and outpatient (n=20) services, all of whom were referred to and seen by the in-house service. 205 (73.2%) set a quit date, of whom 60.9% (125) quit.

Additionally, the reducing smoking in pregnancy referral pathway to smoking cessation services was launched at Ipswich Hospital at the end of January 2023.

West Suffolk Hospital

Between June 2022 and October 2023, West Suffolk Hospital identified 5,265 smokers in acute inpatient (n=5,470) and outpatient (n=15) services. 400 (7.6%) were referred to the in-house service, 365 (91.3%) were seen by the in-house service. 210 (57.5%) set a quit date, of whom 45 (21.4%) were recorded as having quit.

The Trust launched a smokefree maternity pathway, aimed at supporting pregnant people and their households in achieving healthy pregnancies and reducing the risks associated with smoking during and after pregnancy in May 2023.

Norfolk and Waveney ICB

James Paget University Hospital, which is in Norfolk but serves patients in the Waveney area, was a pilot for smoking cessation. There were 13,838 total admissions in 2022/23, of which 6,539 (47.3%) had their smoking status recorded. By the end of quarter three, 805 (12.3%) smokers were referred to stop-smoking services, of which 693 (86.1%) were seen by the service, and 629 (90.6%) were smoke-free at 28 days. 86% of referrals were seen by tobacco advisers, an increase of 75 percentage points when compared to the period before the TDT service started in April 2022.

Between January and October 2023, published data shows 865 smokers were identified in acute inpatients, 825 (95.4%) were referred to the in-house service, 680 (82.4%) were seen and 260 (38.2%) set a quit date, of whom 55 (21.2%) quit. However, suppression has been applied to numbers under 5, and all numbers are rounded to 5, so this should be interpreted with caution.

James Paget maternity services also provides stop smoking support.

Mental health services

Norfolk and Suffolk Foundation Trust (NSFT) provide mental health services (wellbeing, specialist community and in-patient services) across Suffolk and Norfolk.

All in-patients are made aware that NSFT sites are smokefree before admission. The process is as follows:

1. Ask and record every patient's smoking status on admission and provide very brief advice to all smokers.
2. Educate tobacco smokers about NRT and other stop smoking strategies such as e-cigarettes, encourage engagement in tobacco-free treatment care plans and provide NRT or vape as appropriate.

3. Risk assesses patients who smoke and do not wish to abstain from using tobacco – ensure each patient has been offered support and advice with respect to smoking cessation services. Also, if they are unable to leave the ward, they are offered NRT/e-cigarettes to stop withdrawal.
4. Support and conduct a full smoking cessation/ harm reduction assessment for the patient.
5. On discharge ensure they have enough supplies and to refer to Feel Good Suffolk as appropriate.

Between April 2022 and October 2023, 3,340 NSFT patients across community, inpatients, and outpatients services had a recorded smoking status, of which 68.1% (n=2,275) were recorded as smokers compared to 17.0% for England. Numbers should be interpreted with caution as there may be issues with data quality. For example, the number of mental health inpatients who were recorded as smokers (1,670), was higher than the total number of mental health inpatients with any recorded smoking status (1,075). This should not be possible – the number of mental health inpatients with a recorded smoking status should be the same as, or larger, than the number recorded as smokers.

Moreover, all NSFT mental health inpatients were recorded as being referred to an in-house tobacco dependence treatment service. The Care Quality Commission inspection of November 2022 found "Patient care and treatment records evidenced that patients were regularly signposted to smoking cessation services".

East Coast Community Healthcare CIC (providing specialist community mental health) started reporting in April 2023. In the seven months to October 2023, published data shows 15 smokers were identified; all were seen by the in-house service and set a quit date, with 5 quitting (33.3%). However, suppression has been applied to numbers under 5, and all numbers are rounded to 5, so this should be interpreted with caution.

Primary care stop smoking provision

Primary care physicians or GPs and other members of the primary healthcare team are well placed to intervene with smokers, having at their disposal a range of cessation advice during the course of consultation. This section discusses how Suffolk's primary care sector supports smoking cessation.

Pharmacies

In 2022, three pharmacies were reported to provide the smoking cessation advanced service (one in East Suffolk, two in West Suffolk)[197]. None were shown on the NHS smoking cessation service map (data from July 2023).
A Primary Care Contract, for GPs and Pharmacies to deliver Smoking Cessation support, is being discussed between Feel Good Suffolk, Community Pharmacy Suffolk and the Local Medical. Around 10 pharmacies across Suffolk are signed up to offer the full National Stop Smoking Service on hospital discharge (February 2024).

General practice

Feel Good Suffolk does not prescribe medication to support quitting (January 2024). Anyone who wanted to quit using medication would need to work with their GP. Prescription medication to support quitting includes bupropion (Zyban) cytisine (Cytisine), or varenicline (Champix was withdrawn in 2021). Medication and NRT provided by GPs is funded by Public Health and Communities through the ICBs[193].

Apps

Smartphone smoking cessation applications (SCAs) are widely available and extensively used by smokers to aid smoking cessation. However, further study is required to evaluate the effectiveness of SCAs as their low cost, wide availability and absence of side effects may make them useful adjuncts in some populations[198].

There are around 25-30 apps to help people quit smoking available on Google Play or Apply app stores. The NHS have a NHS Quit Smoking app that helps people track their progress, with a target to achieve 28 days smoke-free.

NHS organisations also provide libraries of reviewed apps:

- Humber and North Yorkshire HCP digital health app library
- Shropshire, Telford & Wrekin ICS app finder.

Private treatment

Eight therapy businesses are listed on Suffolk InfoLink as providing general health support, including to quit smoking. Six mention hypnotherapy, and four state they provide services to children and/or young people. The actual number of private businesses supporting smoking cessation is likely to be higher.

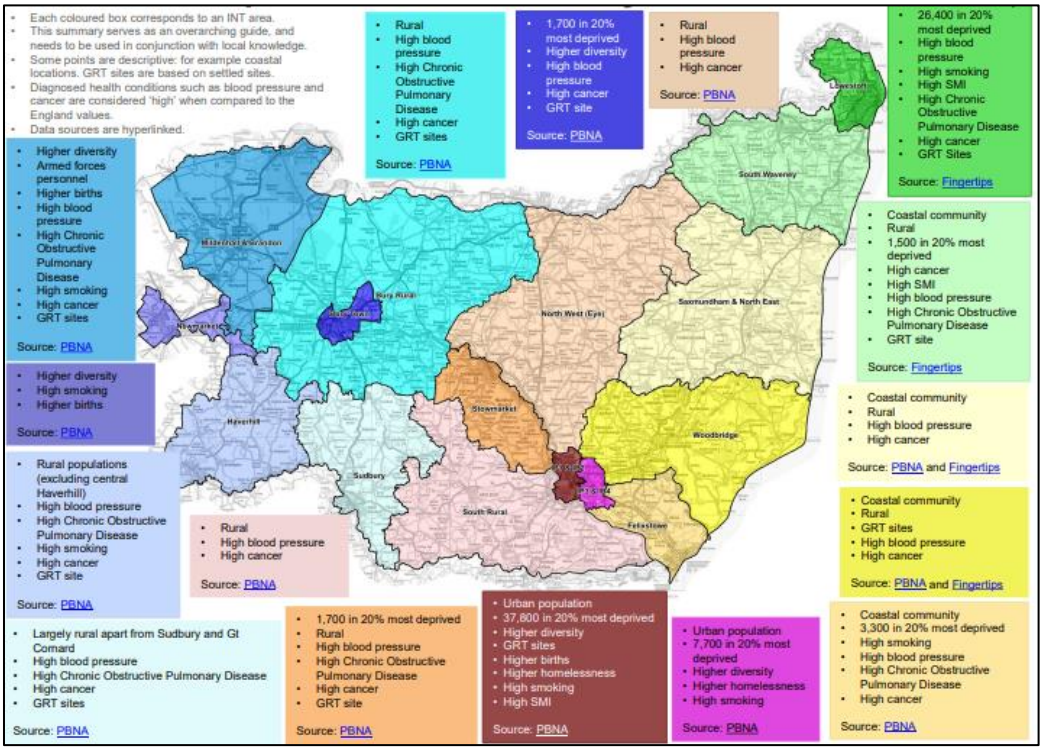
Local plans & strategies

Ambitions around reducing smoking rates, effective tobacco control and controlling long term vaping use and take-up are a priority for many organisations across Suffolk.

Core20PLUS5 is an NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level between 2021-2024. The approach is designed as the NHS contribution to a wider system effort by local authorities, communities and the Voluntary, Community and Social Enterprise (VCSE) sector. One of the cross cutting themes highlighted in the approach is accelerating improvement in smoking cessation.

Figure 33 shows the Core20PLUS5 potential focus areas at integrated neighbourhood team (INTs) level across Suffolk as highlighted in Suffolk's 2022 Annual Public Health Report (APHR). The map highlights that Mildenhall & Brandon, Newmarket, Haverhill, Lowestoft, Felixstowe, and Ipswich (both IP1 & IP2, and IP3 & IP4) all have high smoking rates.

Figure 33: Core20PLUS5 potential focus areas by INT, Suffolk Annual Public Health Report 2022



Source: Suffolk Annual Public Health Report 2022

Suffolk's Health and Wellbeing Board published a Joint Local Health and Wellbeing Strategy for 2022-2027 titled 'Preparing for the Future'. One of the challenges outlined was unhealthy behaviours, such as smoking, contributing to the burden of disease, and years lived with disability. The strategy highlights that work/employment is associated with health damaging behaviours such as smoking and sets a goal for more people in Suffolk to have access to good quality jobs and fair work.

Suffolk North East Essex Integrated Care Board (SNEE ICB) published a Joint Forward Plan (JFP) for 2023-2028. The plan was synthesised on the views of the community and its ambition is to tackle health inequalities, namely the significant gap in life expectancy. One of the key priorities outlined is to support children, adults, and older people to avoid the dangers of tobacco. Plans to enable this include:

- Supporting people to live in a healthier, smokefree environment.
- Sharing public health messages on vaping as smoking cessation.
- Everyone entering hospital as an inpatient in acute mental health or maternity services will be asked about their smoking status.

Collaborative working may support the ability to reach targets set. Norfolk's 2023 APHR focuses on smoking, tobacco control and vaping. The report highlights that several organisations across Norfolk with shared smokefree ambitions including:

- Norfolk and Waveney ICS Integrated Care Strategy and Joint Health and Wellbeing Strategy commits to addressing inequalities and prioritising prevention, to reduce years spent in poor health and differences in life expectancy due to deaths from circulatory, cancer and respiratory diseases, for which smoking is a chief contributor
- Norfolk and Waveney ICS Clinical Strategy commits to acting early to improve health by predicting, detecting and acting early to prevent poor health by helping people make healthy choices, which includes stopping smoking
- Norfolk and Waveney ICS Joint Forward Plan commits to developing and providing a maternity led stop smoking service for pregnant women and partners.
- The ICS Health Improvement Transformation Group has agreed smoking as one of two priority areas for action across the ICS.
- Norfolk County Council's Strategy Better together for Norfolk commits to supporting people to make healthy choices such as providing free stop smoking services.
- Norfolk County Council's Public Health Strategic Plan commits to delivering a new programme of tobacco control and stop smoking initiatives to help people to stop smoking and create smokefree environments.
- The Norfolk Tobacco and Vaping Control Alliances agreed a system-wide programme of work to help Norfolk to become smokefree by 2030 (defined as smoking rates of 5% or less) and developed a vaping delivery plan.

Stopping the start: Smokefree Generation Funding

As discussed in the policy & guidance section of the Health Needs Assessment, on 4 October 2023, the Department of Health and Social Care published a command paper 'Stopping the start: our new plan to create a smokefree generation'. The paper included an increase in funding available for stop smoking services for the next 5 years (2024/25 to 2028/29) to 'expand locally delivered and cost-effective services.

The main aims of this funding are to:

- Stimulate more quit attempts by providing more smokers with advice and swift support
- Linking smokers to the most effective interventions to quit
- Boosting existing behavioural support schemes designed to encourage smokers to quit
- Building capacity in the local areas to respond to increased demand
- Strengthening partnerships in local healthcare systems

Suffolk has been allocated an additional £1,012,764 per annum. This is based on an average 3-year smoking prevalence (2020 to 2022) of 13.9% (84,990 smokers). This funding is additional to the current allocation for stop smoking services. Current spending must be maintained. Suffolk's current annual spend is £1.172,921.

Local authorities received a grant agreement in March 2024, with full grant conditions, for signing and return. The grant agreement will start from 6 April 2024. The grant must be spent in-year (starting 1 April 2024 and ending 31 March 2025) and OHID to be notified of forecasted underspend. Liabilities for eligible expenditure before there is an operational need to do so must not be deliberately incurred.

With this, Suffolk is expected to deliver 14,027 additional quit dates over 5 years- shown in table 21.

Table 21: Predicted quit rates over 5 years including existing activity in Suffolk

Current rate	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total
3,375	4,076	4,778	6,882	7,583	7,583

Suffolk County Councils Public Health and Communities (PH&C) directorate will make decisions on how to increase capacity across the system with the spending uplift, building on existing services highlighted in the Service mapping section of this health needs assessment. It is expected that most of the funding will be spent on the following activities:

1. **Leadership, co-ordination, and commissioning**
   It is expected that an increased leadership capacity and oversight is needed as well as increased co-ordination and commissioning capacity to expand offers to support smokers to quit.

2. **Increasing local resources**
   Recruiting dedicated specialist staff to provide smoking cessation interventions and support to non-specialist advisers.

   Improving the knowledge and skills of non-specialist staff to extend the reach of stop smoking interventions. Providing access to specialist and non-specialist advisers in locations where smokers routinely attend.

   Increasing spend for stop smoking aids for smokers to use in their quit attempts.

   Enhancing service infrastructure, including digital and remote support, establishing physical presence in prominent locations, and conducting targeted outreach efforts, especially for local priority populations.

3. **Increased referral and improved pathways**
   Improvements in referral pathways and increase the number of referrals into local stop smoking services and support is required. This should be done utilising the Very brief advice for smoking cessation: ask, advise, act. Increased partnership working with relevant agencies to tackle health inequalities and increase overall demand for services.

4. **Increased promotion of local stop smoking support**
   Increased marketing and promotion of local interventions to quit smoking- Department of Health and Social Care can work with local authorities who want to use national campaigns locally.

5. **Working together to fund services**
   Local areas can jointly fund activity over a greater geographical area on marketing, service design and delivery and wider tobacco control activities aiming to generate quits.

Recommendations for Suffolk

High Level Recommendation	Specific recommendations
Target Populations **1.** Prioritise and intensify efforts to support smoking cessation among high smoking prevalence groups including those who are at higher risk from the negative health and economic impacts of smoking, and those who may need higher levels of support to stop smoking. **Why?** The data and evidence presented in this HNA indicates there are specific geographical areas and population groups that experience higher smoking prevalence and worse health outcomes.	**1.1 Target geographical areas of high prevalence of smoking** • Babergh, Mildenhall & Brandon, Newmarket, Haverhill, Lowestoft, Felixstowe, and Ipswich (both IP1 & IP2, and IP3 & IP4). **1.2 Routine and Manual workers** • Extend Suffolk's routine and manual worker project to all of Suffolk. • Insight work to understand why Babergh has the highest smoking prevalence in this group (24.8%) and are 3.7 times more likely to smoke than other occupations. • Offer options of intensity of support e.g. light touch with minimal support up to Russell Standard of support. • Continue to use the COM-B behaviour change model to initiate setting of quit dates and engagement. • Build relationships with smokers to ensure quit data is collected. • Address the barrier to quitting e.g. smoking with a drink and fear of weight gain. • Include a specific target group of young women. Nationally, 40% of mothers in routine and manual occupations were most likely to have smoked before or during pregnancy, in 2023/23 20.8% of women aged 20 and under were current smokers at time of booking their maternity appointment. • PH&C complete a profile of routine and manual workers and health in recognition that smoking does not sit in isolation. 1.1 **High socio-economic deprivation** • Refer to the Suffolk Poverty Strategy and work in partnership with the strategy partners to further understand and develop interventions to stop smoking for ○ Smokers in Lowestoft and Ipswich which have the most Local Super Output Areas (LSOAs) with a high Index of Multiple Deprivation (IMD) score.

	○ 2,900 estimated to be out of work and smoking (long term smokers are 7.5% less likely to be employed). ○ 15,000 households with a smoker who fall below the poverty line. ○ 27.2% of those with no qualification who smoke. **1.3 Social housing providers and residents.** *People living in social housing are 3 times more likely to smoke than those in private tenure.* • Use the Suffolk Housing Health Needs Assessment to inform interventions recognising that smoking does not sit in isolation. • Develop targeted initiatives to reduce smoking in tenants and staff. • Additional focus on those who are caregivers to children who reside in social housing. **1.4 People experiencing homelessness and those who support services them.** *75% of people experiencing homelessness wanted to stop smoking (2019)* • Work with homelessness agencies to make smoking a higher priority in their assessments of the heath needs of the people they support. • Consider e-cigarettes and the light touch intervention swap to stop option because they offer a less structured and less formal approach to continue using nicotine. • Work with West Suffolk who have the highest number of homeless households and owed a relief duty (n570). **1.5 People with severe mental illness (SMI) to stop smoking.** *59% people with a SMI smoke.* • Support a SMI Community TDTP discharge pathway to maintain smoking cessation. • Support people with an SMI living in the community to stop smoking. • Focus on Ipswich and East Suffolk which has the highest smoking prevalence of people with a long-term mental health illness. • Explore how to support people to stop smoking with a diagnosis of lower level but ongoing mental health issues such as anxiety, depression, low mood and sleep

	disturbance (prevalence ranging from 40% - 47%) including working with Talking Therapies (Suffolk Wellbeing Service). • Campaigns to educate on smoking's detrimental effects on mental health and myth bust on it relieving stress. **1.6 Substance misuse.** *51% of people who have a substance misuse record with the GP smoke (SNEE). Nationally only 4% of people were recorded as being offered referral for smoking cessation interventions.* • Improve pathways and opportunities for to assist smokers to quit**.** • Carry out further research into what stop smoking interventions work for people with substance misuse. **1.7 Minority ethnic groups. Suffolk has an overall minority ethnic population of 12.7% (2021)** • Work with Gypsy Roma Traveller communities to develop appropriate stop smoking interventions (national data smoking prevalence 24%). Use the GRT Health Needs Assessment to understand wider health and determinants. • Engage with smokers from Polish, Bulgarian, Romanian and Portuguese communities. Provide information in non-English languages. • National data (2022) has 17% of people from mixed ethnic backgrounds as smokers. Research needed in Suffolk to better understand who this is, why this is and how an approach is taken to reduce this prevalence. • Expand research and engagement with minority ethic groups in Suffolk to collect data understand smoking prevalence in populations and ways to support quitting smoking. **1.8 Armed Forces** *(24% smoking prevalence)* **and Veterans** *(up to 1 in 10 with a smoking related disease).* • Take learning from the Tri-Service Tobacco Control Working Group. • Focus on veterans have short service or fail to complete the minimum engagement as they have poorer health outcomes.

	• Focus on the Army who have higher smoking rates. **1.9 LGBTQ+ communities** *Smoking prevalence recorded by people gay or lesbian 22.2% (national data 2018)* • Work with Suffolk LGBTQ+ communities to understand smoking prevalence and stop smoking approach and interventions. **1.10 Cohabiting/single people.** *People that reported 'cohabiting' or 'single' in relation to relationship status had higher smoking prevalence compared to 'married or civil partnership' and 'widowed, divorced or separated'.* • Target smoking cessation initiatives at the 'cohabiting' or 'single' community **1.11 People involved with the criminal justice system and within Suffolk prisons**. *Higher rates of smoking resumption on moving from closed to open conditions was reported.* • Work with Hollesley Bay Category D prison to understand smoking rates, stop smoking provision and support to stop/maintain stop smoking upon release. • Work with probation services to understand and enhance stop smoking support for their clients **1.12 People experiencing violence in their homes.** *Whilst the number is small, local estimates from 2024 indicate that around 2/3rds of people in domestic abuse refuges in Suffolk smoke.* • Work with refuges to understand how to support people who wish to stop smoking. **1.13 People with long term conditions.** *24.4% in Suffolk with a history of smoking within the past year have hypertension. In SNEE ICB around 1 in 10 people with a history of smoking in the past year have chronic respiratory disease.*

	• Collaborations with services and support to understand the barriers to stopping smoking for people with Hypertension and COPD and develop support to assist them to stop smoking.
2. To support pregnant women and the people around them to stop smoking. **Why?** Smoking results in worse health outcomes for both mother and baby and build on existing targeted to minimise the number of women smoking whilst pregnant, and to help them remain smoke free post pregnancy. This aligns with the case for change in the Smokefree Generation legislation. Suffolk's proportion of mothers known to be smokers at the time of delivery was 7.7% (2022/23). In the last 3 years (from 2020/21) percentages have remained relatively static, indicating that there needs to be a renewed focus on smoking cessation in this group. In 2021, the average age of mothers who gave birth in England and Wales was 30.9 years. Over 1 in 4 female smokers are of childbearing age (20-39 years). In 2023/23 20.8% of women aged 20 and under were current smokers at time of booking their maternity appointment.	2.1 Targeted work to support pregnant people to stop smoking in the high-risk population groups identified in Recommendation 1, especially those who are planning a pregnancy, young women or are younger mothers. *In April 2023, the Government announced that all pregnant women who smoke will be offered financial incentives in the form of vouchers alongside behavioural support by the end of 2024.* 2.2 Work with the TDTP to support the new financial incentive scheme for pregnant people and their partners to quit. Ensure smooth pathways in to onwards support, supports this scheme. 2.3 Focus on preventing people from relapsing post pregnancy. • Develop and support specialist stop smoking service for people who are discharged from the maternity TPTP stop smoking pathway and people around a pregnant person to stop smoking. • Consider campaigns to support stopping relapse e.g. other ways to have time away from the children other than smoking.
3. Prevent children and young people from taking up smoking and vaping and support them to stop **Why?**	3.1 At the time of writing this HNA, PH&C are conducting a survey to better understand youth vaping/ smoking across Suffolk. The findings of this survey should be used alongside published research, guidance, and other examples of good practice to influence local plans to prevent young people starting to vape. 3.2 Form and sustain a multi-agency approach to reducing smoking and vaping in young people and preventing uptake.

Smoking is bad for health at any age, and children should not be smoking or vaping. Many adults start smoking in adolescence, and there is an opportunity to prevent smoking in future generations. This aligns with the case for change in the Smokefree Generation legislation, should it be implemented post general election (July 2024) The Healthwatch report and behavioural systems map demonstrated how immediate consequences are more relevant than distant ones (despite the 'cost' of each) for young people. As such, any prevention strategies with children and young people should aim to tackle these challenges.	3.3 Draw from national resources and work regionally with colleagues in the system to create a unified and best practice approach to campaigns, education, and support. 3.4 Involve children and young people and agencies close to them to continue research into smoking and vaping in Suffolk. 3.5 Target work to prevent uptake and reduce smoking and vaping (in never smokers) in the priority groups in recommendation 1. 3.6 Because socially beneficial factors are implicit in starting smoking in CYP, and outweigh factors relating to future health, prevention activities with children and young people should focus on social factors (as well as health). 3.7 Explore how prevention work with young people could utilise immediate consequences (e.g., incentivisation with immediate rewards).
4. Enhance delivery models for stop smoking services and look for opportunities to utilise the additional local funding to facilitate 14,027 additional quit dates over 5-years. **Why?** Public Health and Communities has been allocated £1m/year for 24/25 (with further funding for up to 5 years to be confirmed by the incoming government) for additional stop smoking services. Decisions on how the funding is spent should be informed by the information provided in this Smoking and Vaping HNA. The Healthwatch and behavioural systems map demonstrated that smokers vary on many psychological factors. Yet, self-awareness, and various other self-theories (e.g., ideal self) can help to shape support work. Delivery models can be greatly enhanced by incorporating this insight.	4.1 Prioritise investment in evidence-based and innovative theory-driven tobacco control measures, preferably behaviourally informed and ensure our knowledge of research findings and the evidence base remains up to date, and continuously informs the work to control tobacco in Suffolk. 4.2 Exploring ways to expand the provision of specialist stop smoking programmes tailored to priority groups. Including supporting the TDTP pathways into the community stop smoking provisions. 4.3 Scoping opportunities to provide the health and social care workforce with training on brief interventions and create practitioner networks. 4.4 Working with partners to increase outreach efforts and community involvement in designing initiatives. 4.5 Consider offering cessation services for people who vape, and for young people. There is no current service to support people who vape who wish to quit [source: FGS webinar 2, January 2024).

	4.6 The novel Healthwatch interviews conducted for this HNA influenced some respondents to think about new quit attempts. There is an opportunity here to utilise approaches such as MECC and VBA locally to get more people talking about their experiences of smoking / using tobacco and supporting them to quit. 4.7 When providing interventions consider what influences smokers to continue smoking, barriers to quitting and work alongside agencies who support people with wider determinants. 4.8 Develop a toolkit for stop smoking services that captures the behavioural aspects of smoking to inform a tailored approach to intervention implementation. Use the toolkit to offer tailored and targeted communications and intervention support that leverage suitable intervention functions, geared to heighten self-awareness.
5. Ensure all Suffolk system partners have up to date information about stopping smoking including influences of smoking behaviour and facilitating a desire to stop and the services available to support Suffolk residents. **Why?** It is vital for referring and information sharing organisations have up to date weblinks, literature and referral pathways to the Suffolk stop smoking service and information, Feel Good Suffolk. The Healthwatch report and behavioural systems map demonstrated the importance of leveraging other factors to facilitate a desire to quit (i.e., motivation and emotion) to reach wider audiences. As such, Suffolk system partners would benefit from incorporating these wider behavioural influences and importantly, how to address these influences, into their work.	5.1 Ensure that referring and information sharing organisations have up to date weblinks, literature and referral pathways to the Suffolk stop smoking services and information, Feel Good Suffolk. 5.2 Ensure that service information considers health literacy and low literacy level audiences. 5.3 Explore how these interventions address the specific influences that might challenge these groups to quit smoking? Explore innovative solutions if the interventions are not addressing influences, as well as tighten our understanding of their effectiveness. 5.4 Because a desire to stop smoking varies, and is key in driving behaviour change, system partners' behavioural support and media programmes should broaden the narratives they present directly addressing any elements that would undermine a desire and capitalise on elements known to prompt a desire to change behaviour.

6. Strengthen prevention efforts and de-normalise smoking. **Why?** Universal and targeted campaigns that encourage stopping smoking, swap to stop, and initiatives to prevent smoking initiation may help to reduce smoking prevalence in Suffolk. The Healthwatch report and behavioural systems map indicated how smoking behaviour – particularly relapse - is strengthened the relationship between smoking, stress, and coping. Prevention efforts would benefit by addressing these relationships.	**Implement universal and targeted campaigns.** 6.1 Use behavioural systems mapping to inform campaigns. 6.2 To encourage stopping smoking including the mental health benefits, swap to stop 6.3 Initiatives to prevention smoking initiation 6.4 Using campaigns or interactions with current smokers to discourage smoking around their young people. Focus on parental smoking as this is a significant predictor of children and young people smoking initiation. 6.5 Work with target groups to create appropriate campaigns. 6.6 Work with Suffolk Fire and Rescue Service on an awareness campaign of fires because of smoking materials (see incidents related to smoking). **Create smokefree environments.** 6.7 Work alongside Suffolk workplace initiatives to promote and support smokefree workplaces. 6.8 Work with local authority planning to scope the creation of more smoke-free environments (such as playgrounds, parks, school zones and smoke free events) **Address behavioural relationships.** 6.9 Because stressful life events maintain current smoking AND are implicit in lapse/relapse of quits, stress management should form an important aspect of relapse prevention as part of behavioural support for stopping smoking. 6.10 Similarly, behavioural support should tackle smokers' beliefs about smoking to reduce the likelihood of relapse. 6.11 Stress management courses for current smokers could provide an opportunity to access current smokers and provide them with useful skills / knowledge which could attenuate their psychological reliance on smoking.
7. Promote vaping as a safer alternative for adult smokers who are trying to quit.	7.1 Synchronise and disseminate public health messaging across the system on the relative safety of vaping compared to smoking working with local authority partners,

Why? This is aligned with the Chief Medical Officer's advice from 2023. Using vapes as a quitting tool may be helpful for addicted smokers. It is recognised that the internal behaviour mapping work undertaken for this HNA found views on vaping as a stop smoking tool were mixed. Therefore, a personalised approach to preferred quit methods needs to be adopted wherever possible. The Healthwatch and behavioural systems map demonstrated how multiple biases shape the use of NRTs and vapes, as well as various opportunity and capability elements that challenge the switch to and exit from vaping – warranting a more nuanced approach in promoting vaping as a safe alternative for adult smokers.	stop smoking service, ICBs, INTs, Alliances, VCSE, business and communities. Messaging should follow a recommended framework for behaviour change (e.g., EAST). 7.2 Media campaigns should encompass a broad range of motivations associated with the switch to vaping. 7.3 Aspects of vaping – e.g., smoker's cough, use of disposable vapes – should feature in any education or media campaigns. 7.4 Support healthcare providers in recommending vaping for smoking cessation and promote the Swap to Stop service when appropriate. 7.5 Ensure that up to date information on dual use (vaping and smoking tobacco) is shared with current studies showing that dual use is as harmful as the exclusive use of cigarettes. 7.6 With disposable vapes likely to be banned in England, offer support for disadvantaged groups of smokers, including those who are detained and have dexterity issues and learning difficulties in using reusable vapes, or find alternatives that suit their needs. 7.7 Behavioural support programmes should explore capability and motivation elements to facilitate the entry into vaping and facilitate the exit from vaping by being cognizant of the capability, opportunity and motivation barriers that vaping presents. 7.8 Acknowledge and address the high level of dependency on vape people can feel when they have when they switch to vape and recognise this can be a barrier to people switching (see stakeholder engagement)
8. Ensure that service provision and local strategies meet a high standard in line with national policies and guidance. **Why?**	8.1 Build tobacco control into the strategies and policy of partners in health, social care, district, and boroughs and the VCFSE. 8.2 Ensure services, programmes and projects follow NICE and NCSCT guidance on effective stop smoking interventions and service delivery. Where possible use the Standard Treatment Programme Grade A standard with a minimum of six contacts (weekly or bi-weekly) delivered over 6 to 12 weeks, in person or via telephone or video

Continuing to ensure alignment to key local strategic plans and service provision with national guidance will provide a more robust and coherent local stop smoking service.	link, from a trained stop smoking practitioner. At least 5% of the smoking population should receive a stop smoking intervention delivered by an NCSCT certified stop smoking practitioner. Services should achieve a minimum 35% quit rate. Include CO monitoring when possible. 8.3 Support the implementation of the Tobacco and Vape Bill and "Swap to Stop" scheme. 8.4 Support the NHS CORE20PLUS5 approach to reducing health inequalities. 8.5 Collaborate with enforcement efforts to tackle illicit tobacco and vape product trade. 8.6 Primary care (GPs) should ask all their patients about their smoking status and refer to stop smoking services where appropriate. 8.7 Ensure GP practices with the highest level of smokers are targeted with stop smoking initiatives and provide an in-house stop smoking service. 8.8 Encourage a smoking cessation champion within each primary care setting including Pharmacy. 8.9 Consider equipping pharmacies with CO monitors to enable remote delivery of support. 8.10 Encourage dentists and health and care professionals to have VBA conversations and ensure they have referral pathway information. 8.11 Stop smoking services should provide access to a range of stop smoking methods to quit. 8.12 Support and encourage GP practices and community pharmacies to participate as this is likely to increase the number of people trying to quit.
9. Ensure accurate recording and monitoring of smoking and vaping status within the Suffolk population	9.1 Routinely analyse population health data to identify emerging trends and priority areas. 9.2 Work with Suffolk GPs to increase the completeness of vaping status in primary care records.

Why? Increasing the completeness of smoking and vaping status in primary care records will enable a more complete understanding of the incidence and prevalence of smoking and vaping in the Suffolk population and ensure future decisions about resources or policies in relation to smoking and vaping are based on the most robust data possible.	9.3 Ensure smoking status of all in-patients in acute and maternity settings is recorded. 9.4 Keep up to date with latest research on the long-term health impacts of vaping. 9.5 Effectively evaluate the effectiveness of local strategies and initiatives
10. Enhance cross-sector collaboration and community engagement **Why?** Fostering partnerships with various stakeholders like workplaces, schools, and community groups will increase the visibility of stop smoking services.	10.1 Foster partnerships with various stakeholders like workplaces, schools, and community groups. 10.2 Provide community grants and involve residents in designing local smokefree initiatives. 10.3 Produce a comprehensive marketing and communication plan to increase the visibility of stop smoking services among professionals including health and social care services, Primary Care, the VCSFE.

Who can help in delivering these recommendations?

Who?	Why?
Public Health and Communities (PH&C) Suffolk And the membership of the Suffolk Tobacco Control Alliance (TCA)	PH&C can help with resources allocation, enhance delivery models, prioritise evidence-based tobacco control measures, and strengthen prevention prioritizing smoking cessation among high prevalence groups, pregnant individuals, and young people. The TCA monitors, develops and delivers tobacco control strategy actions.
Local Stop Smoking Service Feel Good Suffolk	To provide high quality stop smoking service that adheres to the NCSCT and NICE guidance, reducing smoking rates using local knowledge and targeted interventions. De-normalize smoking, promote vaping as a safer alternative for those trying to quit, and enhance cross-sector collaboration.
Healthcare settings include GPs, Pharmacies, hospitals, Dentists, Occupational Therapists, Physiotherapists, Mental Health Professionals, Drug and Alcohol services.	Healthcare providers should support smoking cessation, and/or VBA among high-risk groups, pregnant individuals, and their families. De-normalize smoking, promote vaping as a safer alternative for those trying to quit, and enhance cross-sector collaboration. GPs to work on improving the completeness of smoking and vaping status records.
Education settings (Schools, Colleges, Universities)	Educational institutions can help prevent smoking and vaping among children and young people and support cessation efforts for those who have already started.
VCFSE, local support networks, community organisations, Suffolk County Council and District and Boroughs (housing, social care, CYP, as an employer), social housing associations, DWP	Community organisations have widespread reach into local communities that may not be reached via other routes. Local authorities can support smoking cessation promotion, prevent smoking initiation including children and young people, de-normalize smoking through policy, promote vaping as a safer alternative for those trying to quit and enhance cross-sector collaboration. Provide information on available services to tenants, customers and people using services in de-normalize smoking, upskilling staff in very brief advice conversations and disseminating campaign materials.
Researchers and Academic Institutions	There is an opportunity for local researchers and academic institutions to monitor research efforts, particularly related to vaping status and its impact on smoking cessation and long-term health impacts.
Businesses and business sector support networks	Provide information on available services to employees, de-normalize smoking in the workplace and work with stop smoking services to provide access stop smoking opportunities.

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